APPLICATION GUIDANCE
FOR

HEALTHY START INITIATIVE: ELIMINATING DISPARITIES IN PERINATAL HEALTH PROGRAM GUIDANCE FOR OPEN COMPETITION

(CFDA# 93.926E)

February 2000

APPLICATION DUE DATE: March 24, 2000

ANTICIPATED DATE OF AWARD: June 1, 2000

Division of Perinatal Systems and Women's Health
Maternal and Child Health Bureau
Health Resources and Services Administration
Department of Health and Human Services

Electronic Access

Application guidance for MCHB programs is available on the MCHB Homepage via World Wide Web at: http:/www.mchb.gov. Click on the file format you desire, either WordPerfect 6.1 or Adobe Acrobat (The Adobe Acrobat Reader also is available for download on the MCHB Homepage). If you have difficulty accessing the MCHB Homepage via the World Wide Web and need technical assistance, please contact the Information Technology Branch at (301) 443-8989 or webmaster@psc.gov.

NOTE: This document is not a complete kit. The necessary forms are enclosed with this document.
Read this entire document carefully before starting to prepare an application.

HEALTHY START INITIATIVE: ELIMINATING DISPARITIES IN PERINATAL HEALTH PROGRAM GUIDANCE FOR OPEN COMPETITION TABLE OF CONTENTS

Note: A Glossary of Terms, and the Directory of Informational Resources for State Title V Directors, Indian Health Service Area MCH Coordinators and Other Key Resource Staff, HRSA Field Office MCH Program Consultants can be found on the Internet at "http://www.mchb.gov" and "http://www.healthystart.net".

PREFACE

The Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB), a leader in protecting the health of our Nation's mothers and their children, is an outgrowth of the Children's Bureau, founded in 1912. For close to 90 years, MCHB, or its predecessor, has worked toward improving the health or welfare of mothers, infants, children, and youth, and supported a variety of services, including:

- Family planning and counseling
- Well-child clinics
- Immunizations
- Lead poisoning prevention
- Services for low-income and minority women and children
- Community-based, family-centered services for children with special health care needs
- National or regional projects, as follows:
    - -- Research
    - -- Training
    - -- Hemophilia diagnosis and treatment
    - -- Genetic screening, counseling, and referral
    - -- Maternal and child special health improvement projects
    - -- Ryan White Title IV HIV Program for Children, Youth, Women and Families
    - -- Emergency medical services for children
    - -- Infant mortality reduction projects

MCHB administers the national programs on perinatal and women's health with an emphasis on infant mortality reduction. These programs include the Title V Maternal and Child Health Services Block Grant and the Healthy Start Initiative. The Title V Maternal and Child Health Services Block Grant encompasses a national program of block grants to States to assure that mothers (women of childbearing age) and children, especially those with low income or limited availability of health services, have access quality maternal and child services; a program of Special Projects of Regional and National Significance (SPRANS); and a program of Community Integrated Service Systems (CISS) to improve the health of the Nation's families and children. Under Title V, MCHB provides the national focus for leadership in and coordination of Federal, State, local and non-government efforts to promote healthy births and to define the health problems of women of childbearing age and their effects on family members. The Healthy Start Initiative (HSI) focuses on the need to strengthen and enhance community systems of perinatal care and challenges communities to fully address the medical, behavioral and psychosocial needs of women and infants to ensure that all have a healthy start in life. This program centers on: (1) the provision of community-based, culturally sensitive, family-centered, comprehensive perinatal services to women, infants and their families in communities with extremely high rates of infant mortality; and (2) the integration of these services into existing perinatal systems of care.

In addition, MCHB provides funds through many other vehicles, including research grants designed to broaden the maternal and child health knowledge base for maternal and child health programs or programs for children with special health care needs, training grants that focus on providing leadership training within the various health professions for the provision of comprehensive health care to mothers and children, and skills enhancement of State and local maternal and child health personnel.

All of the MCHB-supported services or projects have as their goals the development of (1) more effective ways to coordinate and deliver both already existing and new systems of care, (2) leadership for maternal and child health programs throughout the United States, (3) innovative outreach techniques that can identify and deliver appropriate care and preventive education to at-risk populations, (4) a body of knowledge that can be tapped by any part of the maternal and child health community, and (5) significant, fundamental improvement in the lives and health of our Nation's mothers and their children.

This guidance document addresses the specific requirements for development of applications for Healthy Start Initiative: Eliminating Disparities in Perinatal Health. This grant program is authorized under Section 301 of the Public Health Service Act (42 U.S. Code 241).

CHAPTER I INTRODUCTION

A. Program Background and Objectives

The Healthy Start Initiative (HSI) was initially established as a demonstration program in 1991, based on the premise that community-driven strategies were needed to attack the causes of infant mortality and low birth weight, especially among high risk populations. The principles guiding the planning and operation of the program are innovation, community commitment and involvement, increased access to services, service integration, and personal responsibility. A unique hallmark of the Initiative is the development and mobilization of strong coalitions of consumers, local and State governments, the private sector, schools, providers and neighborhood organizations to address infant mortality reduction within communities by improving health care access and outcomes for women and infants, promoting healthy behaviors and combating the causes of infant mortality.

The Healthy Start Initiative: 1) is committed to implementing innovative community-based interventions to support and improve perinatal delivery systems in project communities; 2) focuses primarily on perinatal and infant clients and their families; 3) strives to assure that every participating woman and infant gains access to the health delivery system and is followed through the continuum of care; and, 4) provides strong linkages with the local and State perinatal system.

During its Demonstration Phase (Phase I) which ended in 1997, there were 22 HSI demonstration projects that developed and implemented community-based strategies to reduce infant mortality in areas with a high incidence of infant mortality. These strategies affected all aspects of the continuum of perinatal care. Perinatal care is defined for the HSI projects as care during the period from preconception through the first year of life (for both the infants and their families).

The primary mission of the HSI during Phase I was to identify and implement a broad range of community-based strategies for significantly reducing infant mortality in communities with a very high rate of infant mortality. Nine categories of community-driven infant mortality reduction strategies have emerged from the HSI demonstration phase, including one organizational model and eight service intervention models. These models are: 1) Community-Based Consortium; 2) Care Coordination/Case Management; 3) Outreach and Client Recruitment; 4) Enhanced Clinical Services; 5) Family Resource Centers; 6) Risk Prevention and Reduction; 7) Facilitating Services; 8) Training and Education; and, 9) Adolescent Programs.

In 1997, the HSI-Phase II broadened its primary mission by initiating support to additional communities seeking to adapt or replicate successful Healthy Start strategies to reduce contributing factors to infant mortality and improve perinatal outcomes in conjunction with individual programs already underway. Currently there are 94 sites. Consideration for funding was given to projects which operationalize one or more of the identified service models of intervention, whose implementation appeared reasonable, appropriate, and could be accomplished within the project period, and that are linked to a perinatal system of care. Because of the commitment to community-based strategies, all HSI projects must have demonstrated evidence of a current working relationship with a community-based consortium that has both: (1) active involvement in the proposed project area;

and, (2) experience with implementing maternal and child health strategies in the proposed project area. This phase has also awarded limited funds for infrastructure building and program planning at the community level to assess a community's needs, resources and capability to adapt Healthy Start models via peer mentoring.

Through a separate, limited competition in 1997, 20 of the 22 HSI projects from Phase I were provided grant funding for (1) continued support of successful strategies and interventions; and (2) peer mentoring of new Healthy Start communities and health care providers, including managed care organizations. These HSI projects offer peer mentoring of those models for which Phase II Federal support has been approved. These projects may also provide mentoring services to new HSI communities for currently operational models which are no longer supported by HSI funds, but were initially developed during the demonstration phase.

The purpose of the HSI-Phase II is to operationalize successful strategies developed during the demonstration phase and to launch Healthy Start projects in new rural and urban communities in conjunction with individual programs already underway. The HSI-Phase II program directly addresses the Healthy People 2010 goal related to eliminating health disparities, and in particular, the objectives related to maternal and infant health.

B. Purpose of Program Guidance

The goal of this grant funding is to enhance a community's service system to address significant disparities in perinatal health indicators. Funding would be made available to up to 10 community projects which have: 1) high infant mortality rates or other significant perinatal health disparities among one or more subpopulations; 2) an existing active consortium of stakeholders with over one year's experience in initiatives related to infant mortality reduction or eliminating disparities in perinatal health; and 3) a feasible plan to reduce barriers, improve the local perinatal system of care, and work towards eliminating existing disparities in perinatal health. In addition, they must demonstrate established linkages with key State and local services and resource systems, such as Title V, Title XIX, Title XXI, WIC, Enterprise Communities/ Empowerment Zones, federally funded community and migrant health centers, and Indian/Tribal Health Services. This program guidance provides detailed instructions for the development and submission of this grant application. Additionally, it provides information on how the application will be competitively reviewed and processed.

Under this competition, HSI funds shall be used to support the implementation and/or adaptation of the essential components of the two (2) required Healthy Start models of consortium, case management. More detailed information regarding these models can be found in Attachment E. Funding for start-up of enhanced clinical services (see Enhanced Clinical Services Model in Attachment E) for targeted individuals residing in the proposed project area leading to reimbursement of these services by Medicaid will be considered pending availability of funds. If any of these models are already adequately provided in the project area through other funding resources, the application narrative should describe how these strategies are integrated into the project plan. HSI funds should not duplicate or supplant existing resources. As funding and infrastructure allow, applicants can request funding to support implementation/ adaptation of other Healthy Start service models.

Successful applicants will be expected to participate as a mentee in the ongoing mentoring process.

C. Maternal and Child Health Bureau Statement

1. Healthy People 2010

The Health Resources and Services Administration (HRSA) and MCHB are committed to achieving the health promotion and disease prevention objectives of Healthy People 2010, a HRSA-led national activity for setting priority areas. Healthy Start addresses issues related to the Healthy People 2010 objectives. Specifically, HSI addresses Healthy People 2010 Objective Numbers: 16-1; 16-5; 16-6; and, 16-10. Healthy People 2010 is for sale by the U.S. Government Printing Office, Superintendent of Documents, Washington, DC 20402-9382, Stock Number 017-001-00543-6, ISBN 0-16-050260-8. For more information about Healthy People 2010 or to access Healthy People 2010 documents online, visit: http://www.health.gov/healthypeople/ or call 1-800-367-4725.

Applicants are encouraged to use Healthy People 2010 Objectives.

2. Pro-Children Act of 1994

The Maternal and Child Health Bureau strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of all tobacco products. In addition, Public Law 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care or early childhood development services are provided to children.

3. Electronic Access

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4. Special Concerns

The Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB) places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care. This same special emphasis applies to improving service delivery to children with special health care needs. In order to assure access and cultural competence, it is expected that projects will involve individuals from the populations to be served in the planning and implementation of the project. The Bureau's intent is to ensure that project interventions are responsive to the cultural and linguistic needs of special populations, that services are accessible to consumers, and that the broadest possible representation of culturally distinct and historically under represented groups is supported through programs and projects sponsored by the MCHB.

Cultural competence is defined as a set of values, behaviors, attitudes, and practices within a system, organization, program or among individuals which enables them to work effectively

cross culturally. Further, it refers to the ability to honor and respect the beliefs, language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long term commitment and is achieved over time.

5. Criteria for Public Health System Reporting Requirements

This program is subject to the Public Health System Reporting Requirements (approved under OMB No. 0937-0195). Under these requirements, the community-based non-governmental applicant must prepare and submit a Public Health System Impact Statement (PHSIS). The PHSIS must be submitted with this application and concurrently to the State health agency. The PHSIS is intended to provide information to State and local health officials to keep them apprised of proposed health services grant applications submitted by community-based non-governmental organizations within their jurisdictions.

Community-based non-governmental applicants are required to submit the following information to the head of the appropriate State and local health agencies in the targeted area(s) no later than the federal application receipt due date:

- A copy of the face page of the application (SF 424);

- A summary of the project (PHSIS), not to exceed one page, which provides:
  -- A description of the population to be served;
  -- A summary of the services to be provided; and
  -- A description of the coordination planned with the appropriate State and local health agencies.

The project abstract may be used in lieu of the one-page PHSIS if the applicant is required to submit a PHSIS.

6. Evaluation Protocol

A Maternal and Child Health discretionary grant project, including any project awarded as part of the Healthy Start program, is expected to incorporate a carefully designed protocol capable of documenting measurable progress toward achieving the stated goals. The protocol should be based on a rationale relating the project activities, goals, and performance measures. The measurement of progress toward goals should focus on health outcome indicators, rather than on intermediate measures such as process or outputs. A project lacking a complete and well-conceived evaluation protocol may not be funded.

Grantees under the HSI program are required to report annually to MCHB the number of persons served or trained (by race and ethnicity) and types and volume of services provided, infant mortality and morbidity rates, and related HSI model information. Data forms for this purpose will be provided by MCHB to all grantees during the first grant year. Data elements included in these forms are identified in Attachment G.

D. Federal Responsibilities

Once the grant is awarded, MCHB will monitor and evaluate the project activities funded under this competition. Program monitoring may include guidance, consultation, technical assistance, facilitation of peer mentoring, and coordination and participation in programmatic activities. Periodic meetings, conferences, and/or communications with the award recipients are conducted to review mutually agreed upon goals and objectives, to assess progress, and to provide technical assistance. The outcome of monitoring activities could lead to adjustments in funding and priority tasks for a project.

CHAPTER II APPLICATION AND REVIEW PROCESS

A. Who Can Apply for Funds

1. Eligible Applicants

Applicants for this funding competition under the Healthy Start Initiative must be public or non-profit private organizations, or tribal and other organizations (e.g., those representing Hispanics, American Indians, Alaska Natives Asian/Pacific Islanders, and immigrant populations) applying as or on behalf of an existing community-based consortium. An eligible applicant must have direct fiduciary responsibility over the administration and management of the project.

Please Note: ***Healthy Start implementation grantees that do not have one of the current Healthy Start Infrastructure grants are not eligible to apply.***

2. Eligible Project Area

A project area is defined as a geographic area in which the proposed model(s) are to be implemented. A project area must represent a reasonable and logical catchment area, but the defined areas do not have to be contiguous. Communities experiencing serious problems with infant mortality in the catchment area are eligible to apply, especially communities where racial and ethnic disparities in perinatal indicators exist. "Communities" is broadly defined so that a statewide or multi-county project serving racial/ethnic groups (e.g. Hmongs, Mexican Hispanics, border counties, etc.) would be eligible.

3. Eligibility Factors Demonstrating Disparities

An applicant's project areas must meet the following verifiable criteria. MCHB may verify submitted data with the appropriate State/local government agency responsible for Vital Statistics. Border communities that cannot obtain this verifiable data may use the other indicators specified in the second section below. Project data for the eligibility factors for all applicants must be documented in the application's cover letter and in the needs assessment section of the submitted application. The existing racial/ethnic disparities in these or other perinatal indicators should be described in the needs assessment section of the application.

a. Non-Border Communities (using verifiable three year average data for 1995-1997, unless otherwise specified): Proposed project area must have for one or more racial/ethnic groups a three year average Infant Mortality Rate of at least 11.1 deaths/1000 live births, and at least 3 of the following:

- Percentage of births to teens (less than 18 years of age) which exceeded the national average of 5.1 % of all live births;
- Percentage of Low Birth Weight births which exceeded the national average of 7.4 % of all live births;
- Postneonatal mortality rate exceeded national average of 2.6 deaths per 1,000 live births;
- Percentage of children under 18 years of age with family incomes below the Federal Poverty Level exceeded 19.9% for 1990. If more recent verifiable poverty data is available, please provide this data and identify year and source.

b. **Border Communities** (using verifiable three year average data for 1995-1997 unless otherwise specified): The proposed project area for communities which meet border community definition (i.e., within 62 miles from the Mexican border) must meet at least 4 indicators from the list below. If vital statistics are not available from State/ local government agencies, border community applicants can use other verifiable clinic data.

Maternal Indicators[1]

- Percentage of pregnant women with anemia/iron deficiency is 20% or more;
- Percentage of pregnant women entering prenatal care in the first trimester is less than 80%;
- Percentage of pregnant women entering prenatal care in the third trimester is greater than 4%;
- Percentage of births to women who had no prenatal care is greater than 2%;
- Percentage of births to women who had entered prenatal care in the third trimester or who had no Prenatal Care is greater than 6%;
- Percentage of birth to women who had fewer than 3 prenatal clinic visits during pregnancy is greater than 30%;
- Percentage of Women of Child Bearing Age (WCBA) who are uninsured is greater than 35%;
- Percentage of pregnant women who have had a previous birth within the past two years (interconceptional interval <2 years) is greater than 25%;
- Percentage of WCBA with less than a High School Education is greater than 31%.

Infant Indicators[2]

- Percentage of children 0-1 years old with a completed schedule of immunizations is less than 60%;
- Percentage of infants in the bottom 10% on the growth/weight chart is greater than 25%.

Poverty Indicators

- Percentage of children under 18 years of age with family incomes below the Federal Poverty Level exceeded 19.9% for 1990. If more recent verifiable poverty data is available, please provide this data and identify year and source.

4. Funding Preferences and Priorities:

Funding preferences will be given to the following:

- past (FY 1999) projects of HSI-Infrastructure /Capacity Building grants; and
- communities in States and territories which do not have a currently federally-funded Healthy Start project.

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[1] If verifiable clinical data is used, for each indicator divide the number of pregnant or perinatal clients having the identical risk factor by the total number of pregnant or perinatal clients served annually. The data source for each indicator used must be provided in the application.

[2] If verifiable clinical data is used, for each indicator divide the number of infant clients (newborn to 1 yr olds) having the identical risk factor by the total number of infant clients served annually. The data source for each indicator used must be provided in the application.

Funding priorities will be given to the following:

- communities with significant racial/ethnic disparities in perinatal indicators for 3 years (1995-1997) for which data are available;
- border communities (within 62 miles of the Mexican border); and
- proposals with emphasis/specific activities addressing qualitative issues (e.g., social/economic, violence, psychological services) for its perinatal populations. This need must be well documented in the needs assessment and implementation plan.

B. Funding Particulars

Five million dollars is available to fund up to 10 new communities or projects with awards up to $500,000 per project for the first year. Pending availability of funds and adequate progress, project periods for the grants under this competition will be up to 4 years, starting June 1, 2000 and concluding on May 31, 2004. The first budget period will be for one year: June 1, 2000 - May 31, 2001.

1. Official Application Kit

Application guidance for MCHB programs is available on the MCHB Homepage via World Wide Web at: http://www.mchb.gov. Click on the file format you desire, either WordPerfect 6.1 or Adobe Acrobat (The Adobe Acrobat Reader also is available for download on the MCHB Homepage). If you have difficulty accessing the MCHB Homepage via the World Wide Web and need technical assistance, please contact the Information Technology Branch at 301-443-8989 or webmaster@psc.gov.

A hard copy of the official grant application kit (Revised PHS Form 5161-1, approved under OMB clearance number 0937-0189) must be obtained from the HRSA Grants Application Center. The Center may be contacted by telephone: 1-877-477- 2123 ; FAX: (703)-528-0716; or E-mail: "HRSAGAC@ HRSA.gov". The kit includes an acknowledgment card, PHS Form 3038, which must be completed and submitted with the application. HRSA Grants Application Center staff will detach half of the acknowledgment card and mail it to the applicant to confirm receipt of the application. If the card is not received within 15 days of submitting the application, applicants should contact the HRSA Grants Application Center to determine the status of the application.

2. Notification of Intent to Apply:

If you intend to submit an application for this competition, please notify the Division of Perinatal Systems and Women's Health of MCHB by **February 24, 2000.** Please include in the notification the name, address, phone and fax numbers, and E-mail of the person who should be contacted in the event MCHB needs to provide additional guidance regarding the grant application. You may signify your intent to apply in any of the following ways:

Fax: Maribeth Badura
(301) 594-0186

Electronic Mail: mbadura@hrsa.gov

Mail: Maribeth Badura
Division of Perinatal Systems and Women's Health, MCHB
Parklawn Building, 11A-05
5600 Fishers Lane
Rockville, Maryland 20857

3. Application Due Date

The application deadline date is **Friday, March 24, 2000.** Applications will be considered as having met the deadline if they are: 1) received on or before the deadline date, or 2) are postmarked on or before the deadline date and received in time for orderly processing and submission to the review committee. (Applicants should request a legibly dated receipt from a commercial carrier or U.S. Postal Service postmark. Private metered postmarks will not be acceptable as proof of timely mailing.)

4. Mailing Address

All applications should be mailed or delivered to:

HRSA Grants Application Center/CFDA **#93.926E**
ATTN: Maria Carter, Grants Management Specialist
1815 North Fort Myer Drive, Suite 300
Arlington, VA 22209
Telephone: 1-877-477-2123

Grant applications sent to any address other than the above are subject to being returned.

5. Number of Copies:

Applicants are required to submit one ink-signed original and two copies of the completed application. A total of six copies will be used during the review process. Additional submission of three more copies by the applicant is optional. Disk copies of the submitted application narrative and the abstract in a format which can be imported into Word Perfect must also be submitted.

C. Applicant Assistance

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to the awarding of grants under the Healthy Start Initiative by contacting:

Maria Carter, Grants Management Specialist
Maternal and Child Health Bureau, HRSA
Parklawn Building, Room 18-12
5600 Fishers Lane
Rockville, Maryland 20857
Telephone: (301) 443-1440

Applicants may also obtain additional information relating to technical and program issues from Maribeth Badura, Division of Perinatal Systems and Women's Health, at (301) 443-8283 or "mbadura@hrsa.gov". Information is also available on the MCHB website at http://www.mchb.gov, and on the Healthy Start website at www.healthystart.net.

D. Review Process and Criteria

The review process for this open competition for grant applications will involve, at a minimum, reviews by an Objective Review Committee (ORC) composed of Federal and non-Federal persons experienced in the organization and delivery of community-based infant mortality reduction projects. Depending on the number of applications, there may be separate ORC panels for urban and rural applicants[3]. The ORC will evaluate all eligible applications using the following weighted Review Factors and Criteria:

- **Factor I (Weight 5%): Quality of the project abstract**
- **Factor II (Weight 35%): Adequacy of the project plan**
- **Factor III Weight 20%): Applicant's capability and/or capacity**
- **Factor IV (Weight 10%): Evidence of support and/or linkage to the perinatal system**

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[3] According to the 1990 census definition, the urban population comprises all persons living in: (a) places of 2,500 or more inhabitants incorporated as cities, villages, boroughs (except in Alaska and New York) and towns (except in the New England states, New York and Wisconsin), but excluding the persons living in the rural portions of extended cities (places with low population density in one or more large parts of their area); (b) census designated places (previously termed unincorporated) of 2,500 or more inhabitants; and (c) other territory, incorporated or unincorporated, included in urbanized areas. An urbanized area comprises one or more places and the adjacent densely populated settled surrounding territory that together have a minimum population of 50,000 persons. In all definitions, the population not classified as urban constitutes the rural population. (Source: US Dept. of Commerce, "Statistical Abstract of the United States - 1995. The National Data Book" Washington, D.C., 1995, p. 4).

- **Factor V (Weight 15%): Structure and role of the consortium**
- **Factor VI (Weight 15%): Appropriateness of the budget**

As part of the review, a site visit may be conducted to validate information submitted in the application and to assess the following:

I. Applicant's Capability
II. Consortium Role and Structure
III. State and Local Perinatal System Linkage
IV. Other Issues As Appropriate.

CHAPTER III REQUIREMENTS FOR PROJECT NARRATIVE

A. Project Abstract

This document may be used in lieu of the one-page Public Health System Impact Statement (PHSIS) if the applicant is required to submit a PHSIS. See Chapter I, Section C.5 and Attachment C for Instructions on preparing the PHSIS if required.

1. Summary of Project Narrative

Applicant should prepare the **two to four page** abstract describing its proposed project according to the outline provided in Attachment A. This summary of the project narrative (i.e., Project Abstract) is an important mechanism for dissemination of information about MCHB funded projects. The abstracts publication, MCHB Abstract of Active Projects, is widely distributed to MCHB grantees, State Title V programs, academic institutions, and governmental agencies.

2. Text of Annotation

Prepare a three to five sentence description of the project that identifies the purpose and problems addressed, the goals and objectives of the project, the activities to attain these goals, and the materials developed.

3. Key Words

Key words are the terms under which the project will be listed in the subject index of the MCHB Abstract of Active Projects (see Attachment A-1). Select the most significant terms that describe the project, including the population served.

See Attachment A-2 for a sample Project Abstract and Attachment C for a discussion of the proper format for the Abstract.

B. Project Narrative

The narrative is not to exceed 75 pages. Applicants must pay particular attention to structuring the narrative to respond clearly and fully to each review factor and associated criteria. The narrative must incorporate the headings and subheadings as they appear below. For each heading/subheading, the review factor and associated criteria will be stated, followed by instructions for the applicant that outline the minimal information required by the factor/criteria. Each of the nine models has been defined in the Healthy Start Models of Intervention (see Attachment E).

Factor I. (Weight 5%): The quality of the project abstract as measured by the clarity of the project abstract including an adequate and succinct text of annotation and the provision of a list of key words.

Factor II. (Weight 35%): The adequacy of the proposed project plan, as measured by the following:

A. The extent to which the demonstrated need(s) of the target population to be served are adequately described and supported in the needs assessment and summarized in the problem statement.
B. The extent to which the proposed plan addresses the documented need(s) of the targeted population, including attention to the cultural and linguistic needs of consumers.
C. The extent to which each proposed approach is congruent with the scopes of the two required and any additional proposed service models of intervention.
D. The extent to which a proposed approach delineates the specific model strategies included in the plan, and identifies the actual or anticipated agencies and resources which will be used to implement those strategies.
E. The extent to which the proposed plan will enhance existing infant mortality reduction activities already underway in the community.
F. The extent to which the project objectives incorporate performance-based indicators and are measurable, logical, and appropriate in relation to both the specific problems and Healthy Start model(s) identified.
G. The extent to which the activities involved in the approach to each model appear feasible and likely to contribute to the achievement of the project's objectives within each budget period.
H. The extent to which the plan to measure program performance is well organized, adequately described, and complies with MCHB's evaluation protocol for its discretionary grants.

1. <u>Project Area Needs Assessment</u>

Analyze the needs of the project area, and the adequacy and accessibility of resources to address those needs. All applicants must submit the findings of their needs assessment for the project area which at a minimum covers all of the areas detailed below for the three year (1995-1997) period unless otherwise specified; 1998 data should also be provided if such verifiable (non-provisional) information is available. With the exception of items specified in the eligibility section, the applicant may submit estimates using county or city level figures if project area-specific data are not available. Applicants must cite sources, year, and formulae for estimates, where applicable, for each required item. Applicants should highlight existing racial/ethnic disparities observed in the proposed project area for any of these variables. Applicants are encouraged to utilize all data sources available.

The appropriate Title V or IHS Area MCH Coordinator would be a valuable potential resource for this information. Directories of such coordinators and those MCH Program Consultants in the HRSA Field Offices are available on the World Wide Web at "http://www.mchb.gov" and "http:/www.healthystart.net".

Tabular statistical data, maps, and charts such as the suggested "Demographic and Statistical Data Form" should be included in Appendix A; however, the narrative should integrate that information into its analysis and appropriately cross-referenced. A table containing the minimum demographic and perinatal health statistics for the project area is required; a suggested format for

reporting this data is found in Attachment D, "Demographic and Statistical Data Form." Information contained in the narrative and in the suggested data tables should identify and explain any variances in the project area (e.g., hospital catchment areas, regional health care centers or trend in crime or substance abuse/drug trafficking, etc.).

a. Geographic Description of Project Area: Provide a demographic profile of the project area, including size (square miles), location, type (i.e., rural or urban), population composition by race, age, employment levels, and current major industries.

b. Project Area Map: Provide a legible map(s) of the project area reflecting its boundaries and relation to the city/county and the location of major health providers, and community health centers.

c. Population: Provide the total population and number of women of childbearing age (WCBA) residing in the project area, by race and ethnic origin (i.e., Total, White, Black, Other races, and those of Hispanic Origin). Use 1990 national census data. Note that "Hispanic persons are persons of any race who report/identify themselves as Mexican-American, Chicano, Mexican, Puerto Rican, Cuban, Central or South American (Spanish countries) or other Hispanic origin." Source: U.S. Bureau of Census, The Statistical Abstract of the United States, (115th ed.), Washington, D.C., 1995, p.5. **In the following Population characteristics, emphasize any perinatal disparities which exist in the proposed project area.**

1. Behavioral and Environmental Factors: Describe the prevalence of unique risk and other factors causing or contributing to infant mortality. Special consideration should be given to factors associated with self-imposed risks arising from behaviors or lifestyles (e.g., substance abuse, smoking); also consider factors associated with living environments, economic, and other social variables (e.g., domestic/family violence, crime levels, and homelessness).

2. Poverty Level: a) Provide the percentage of total population by racial and ethnic origin living at and below *185% of the 1990 Federal Poverty Level*; and, b) Provide the percentage of children under 18 (by racial and ethnic origin if available) with family incomes *below the 1990 Federal Poverty Level.* If data are available in the project area for the percentage of uninsured and/or underinsured families, please submit. If Year 2000 preliminary census data is available, please submit.

3. Maternal Educational Level: Provide the 1990 census level for the number of WCBA who had achieved less than a high school education at the time of delivery. If 2000 preliminary census data is available, please submit.

4. Perinatal Measures: For the total project area population and by racial origin, provide three year averages (1995-1997) unless otherwise indicated for the project area's

number of:

- Live births and infant deaths (under 1 year of age);
- Births to teenagers 18 years of age or younger;
- Births to women who received prenatal care during their first trimester
- Births to women who received no prenatal care;
- Live births with positive drug screens during 1997;
- Women with positive HIV screening at the time of delivery

5. Infant Mortality and Low Birthweight Indicators: Analyze the trends and contributing factors to infant mortality and birthweight distribution within the project area. Include data by racial breakdown for total infant, neonatal, and post-neonatal mortality rates. Similar statistics and analysis should be provided regarding the incidence of low birth weight births (<2500 grams/or 5.8 lbs.). To substantiate the trends of these variables, provide verifiable 3 year average data for the periods 1992-1994 and 1995-1997; 1998 data should be provided if available.

6. Infant Health Status Measures: All HSI projects are required to serve infants up to one year of age. Describe current trends in infant morbidity, including such areas as prematurity, birth defects, child/infant abuse and neglect, accidents, AIDS, other communicable diseases, and any other prevalent factor(s) affecting the project area. While other indicators of infant health should be discussed, it is required that the projects comply with and report on the Year 2000 immunization objective (Healthy People 2000, objective 20.11). The immunization rate (ages 0- 2) for the project area for 1995, 1997 and the most current year should be indicated.

d. Current Perinatal Health Care Delivery System: Highlighting any perinatal disparities, please describe:

- The current number and client capacity of the following perinatal providers and facilities (including anticipated closures and new construction) that are known to be actively serving the Medicaid and uninsured populations in the project area: hospitals, community health centers (CHC); migrant health centers (MHC); Federally Qualified Health Centers (FQHC), birthing centers, health care facilities for the homeless serving perinatal clients; physicians, obstetricians, pediatricians; perinatologists, neonatologists, certified nurse midwives, and nurse practitioners.
- Case management and outreach programs currently in existence including the current number of providers, current client capacity for the population targeted under this initiative, and highlight the unmet needs;
- Linkages with tertiary/regional perinatal centers, and specific gaps in the local perinatal health care system utilized by the target population; and
- The status of public and private providers in team building, (e.g., the presence, absence, planning or closure of Fetal Infant Mortality Review, hotline management and referral systems) and in-service training efforts, and describe current MCH linkages and referral patterns.

e. Access to Perinatal Services: The utilization of perinatal services is enhanced when there is adequate access to these services. Adequate access includes transportation, child care, and translation services. Describe the current capacities of existing public and private resources providing transportation, child care, and translation services to the project area. Describe the levels of current utilization and of the unmet need for each of these three services in relation to accessing perinatal services.

2. Problem Statement

Based on the needs assessment and disparities, the applicant should provide a problem statement that succinctly summarizes the needs of the target population in relation to the identified disparities and overall infant mortality reduction. The problem statement should include a summary of problems/factors impacting the project area's perinatal health status and delineate those problems/factors to be addressed by the proposed models of intervention. The models of intervention should be directed toward the elimination of racial/ethnic disparities and increased access to perinatal care.

3. Proposed Project Approach

a. Project Plan Model(s)

Applicants under this competition are required to provide for all targeted individuals the Healthy Start models of :

- Consortium; and,
- Care Coordination/Case Management.

As funding and infrastructure allow, applicants can also request funding to support implementation/adaptation of other Healthy Start service models:

- Outreach and Client Recruitment;
- Start up of Enhanced Clinical Services (Enhanced Clinical can include Family Resource Centers);
- Family Resource Centers;
- Risk Prevention and Reduction;
- Facilitating Services;
- Training and Education; and,
- Adolescent Programs.

A more detailed description of each of these nine models, the model-specific Needs Assessment Indicators, and the suggested model-specific Performance Indicators are available in Attachment E.

In the introductory paragraph for this section of the project plan, the applicant should cite the project's goal(s) and itemize all the models proposed to accomplish these goals under

this grant along with the project period objectives for each model. As the funding period for this grant is four (4) years, calendar year objectives for each year of the project must be defined for each model. (The calendar year objective is the intended progress for each year of the grant, while the project period objective is the overall change intended by the completion of the grant period. Therefore, the calendar year objective for the last year of the grant should coincide with the project period objective. See example on page 16.) A separate budget justification for each year of the project must also be provided. Then, for each model, complete all of the components in this section before introducing the next model.

Please note that each model should be able to stand alone, and not be dependent upon another model within the same application. If the applicant is not requesting HSI funds to support either of the required models, the needs assessment must present evidence documenting how these specific needs of the target population are currently being met. If the applicant proposes to implement or adapt more than the two required Healthy Start models, there is the possibility that some of the optional models may not be approved for funding.

b. Model Specific Needs Assessment

In addition to the information in the general needs assessment of the project area (Section B.1), the applicant should address the model-specific needs indicators found in Attachment E and the unique service, cultural and linguistic needs and disparities of consumers residing in the project area which are pertinent to the model. The specific health problem(s) which the model addresses must be stated in terms of measurable health outcomes or system gaps/deficits.

c. Model Description

The applicant should describe the model of service intervention, including:

- the proposed strategies with timeframes;
- anticipated/actual providers/contractors of component services;
- all funding resources (including in-kind contributions);
- target populations; and
- projected service utilization levels for each year.

The narrative for this section should delineate how the model will be linked to existing infant mortality reduction activities, particularly existing State and local MCH programs. These activities should help to eliminate racial/ethnic disparities and /or increase access to perinatal services already underway in the community. This section should conclude with a discussion of actions planned to secure future funding of the model strategies after the conclusion of HSI support, and/or for incorporation of these activities into the applicant's ongoing programs. A suggested format for the Implementation Plan can be found in Attachment H.

d. Model Specific Objectives and Performance Indicators

Each model for which HSI funding is being requested should reflect thorough planning; all proposed component strategies should have measurable objectives clearly related to the goal of eliminating disparities in perinatal health within the project area. *For each model*, calendar

year objectives must be provided for each year of requested funding. The objectives should be based on and clearly relate to both the general and model-specific needs assessments presented in previous sections of the narrative. Each objective should be time-framed, measurable, outcome-oriented and realistic for the resources available, and capable of being feasibly accomplished within the specified time frames. Each proposed objective should include a baseline which will be used as a basis for comparison with data from subsequent measurements of the specific health problem(s) to determine whether or not the project is having its intended impact. When utilizing baseline data, applicants must document the data source for both the baseline and the current status. If percentages are used, the relevant numerator and denominator must be cited. Based on the performance indicators, project period objectives and calendar year objectives for each year of grant funding must be submitted. Baselines must be established utilizing the most current data source available prior to implementation of services using HSI funds.

Example:

Project Period Objective: By 6/1/04, increase to at least 80% the number of postpartum women who receive interconceptional services each year.

Calendar Year 4 Objective: By 6/1/04, 80% (380) of the 475 postpartum women who were enrolled in the Case Management Program, will make at least one visit to a health care provider for interconceptional/family planning services during the reporting period. (This represents the 6 months of data concluding the project period.)

Calendar Year 3 Objective: By 12/31/2003, 77.6% (349) of 450 postpartum women who were enrolled in the Case Management Program, will make at least one visit to a health care provider for interconceptional/family planning services during the reporting period.

Calendar Year 2 Objective: By 12/31/2002, 75% (319) of 425 postpartum women who were enrolled in the Case Management Program, will make at least one visit to a health care provider for interconceptional/family planning services during the reporting period.

Calendar Year 1 Objective: By 12/31/2001, 72.5% (290) of 400 postpartum women who were enrolled in the Case Management Program, will make at least one visit to a health care provider for interconceptional/family planning services.

Baseline: Among the 400 participating postpartum women who were enrolled in case management services in 1998, only 280 or 70% (280/400) reported making at least one visit to a health care provider for interconceptional /family planning services. (Source: case management log, patient, provider and program records)

Project Performance Indicator: Percentage of participating postpartum women who are enrolled in case management services and receive interconceptional/postpartum services.

For this section of the project narrative, state the objective(s) for the model, and the required components [proposed objective, baseline, performance indicator(s)]. Each objective should clearly relate to proposed activities for each model. See Attachment E for suggested performance indicators.

4. Proposed Evaluation

Local evaluations play a vital role in providing projects with timely information on the implementation of their intervention strategies. The applicant's evaluation protocol must:

- be well-planned, and capable of demonstrating and documenting measurable progress toward achieving its stated project objectives;
- be based on a clear rationale related to the grant activities and consistent with theevaluation measures;
- include measurements of progress (i.e., outcome performance indicators) which focus on health outcome indicators, rather than on intermediate measures such as process or outputs;:
- incorporate model-specific and valid measures of health outcomes, such as changes in health status when grant activities address one or more specific health problems include an evaluation design, data collection methods (e.g., pre/post tests, questionnaires, patient satisfaction surveys), analytic techniques, evaluation measures and time frames, and data sources. Issues relating to reliability and validity, ancillary and supplemental techniques/analyses must be adequately addressed;
- identify the agency and the individual primarily responsible for overseeing the conduct of the local evaluation. A curriculum vitae of the evaluator should be included in Appendix C.

In this section of the narrative, describe the design, resources, and time line for implementing the project's evaluation to comply with the expectations cited above. Applicants lacking a complete and well-conceived evaluation protocol as part of the planned activities may not be funded. Additional information on the Evaluation including a suggested format is included in Attachment I.

Grantees selected under this funding competition are required to report annually to MCHB the number of persons served or trained (by race and ethnicity) and types and volume of services provided, infant mortality and morbidity rates, and related HSI model information. Data forms for this purpose will be provided by MCHB to all grantees during the first grant year. Data elements included in these forms are identified in Attachment G.

5. Applicant's Capacities and Capabilities

Factor III. (Weight 20%): The applicant's fiscal and program management capability and/or capacity, as measured by:

A. The extent of the applicant's capability to carry out the replication or adaptation of the model(s) within the project area.

B. The extent to which the applicant has demonstrated an ability to maximize and coordinate existing resources and acquire additional resources.

a. Applicant's Organizational Capacity:

A successful applicant will be the entity responsible for directly administering the project and will have the fiduciary responsibility for the grant funds, including the contracting of any activities using those funds. Applicant organizations are expected to have sound systems, policies, and procedures in place for managing funds, equipment, and personnel to receive grant support. Applicants who propose subcontracting these administrative or fiduciary responsibilities for the project will not be approved for funding. All successful applicants "must perform a substantive role in carrying out project activities and not merely serve as a conduit for an award to another party or to provide funds to an ineligible party" (See Chapter 8, Post Award Administration, Contracts for Substantive Programmatic Work, of the PHS Grants Policy Statement). The applicant will have primary responsibility for monitoring the progress of the project toward its goals and objectives, including monitoring contract deliverables. It will hire key personnel, will be responsible for communication with the consortium organization (if applicant is a consortium, it will be responsible for communication within the consortium and with the community), and will coordinate the preparation and submission of required reports and continuation grant applications for future years.

All applicants need to briefly describe:

- History and organizational structure of the agency;
- History of the applicant's relationship to the project;
- History of involvement and accomplishments in MCH activities, especially those related to infant mortality reduction, in the community and project area;
- History of sound management and oversight involving other grant or contractual funds;
- Status of its current relationship and its history with the required consortium, including the scope of authority (i.e. roles and lines of communication) between the applicant and consortium;
- The plan for the administrative and financial management of the project, including a description of the process for making decisions and operating relationships between and among the applicant, individual service providers, and consortium; provide an organizational chart specifically denoting where in the agency the direct oversight/ administrative responsibilities of the project will be housed;
- The staffing plan (excluding contractor's staff) which identifies positions that will provide personnel for essential programmatic, fiscal and evaluation activities. Key personnel should have adequate qualifications, appropriate experience and allocated time (% FTE) to fulfill their proposed responsibilities. Position descriptions and curricula vitae of Key Personnel for the project (e.g., Project Director, Chief Fiscal officer, Program Coordinator, Evaluation Coordinator) should be placed in Appendix B;
- The methodologies for soliciting, awarding, and the fiscal and program monitoring of contracts and subcontracts. Methodologies used for monitoring utilization and quality assurance (including client satisfaction) of all activities and services should also be summarized and

sample documents provided if available;

- Summarize the coordination among key program, fiscal, and evaluation staff by describing how often the three groups of staff members will meet with each other, and whether this is a formalized and regularly scheduled meeting. Identify to what extent members of each group will work jointly with contractor staff on monitoring and technical assistance activities;
- Samples of formal agreements and letters of understanding with appropriate, actual or anticipated major contractors should be included in the Appendix B; and,
- If deficiencies have been noted in the most recent internal/external audit, review, or reports on the applicant organization's financial management system and management capacity or its implementation of these systems, policies and procedures, identify the corrective action taken to remedy the deficiency. Once approved for funding, all HSI grantees are now required to submit copies of their annual audits with each application for continued funding.

b. Applicant's Capacity for Sustainability:

Summarize in this section all activities during the past two years directed at maximization of resources for the continuation of services under other grants/contracts; also include plans for sustainability subsequent to HSI funding. Resources include agency MCH funds, in-kind contributions, and third party reimbursements (e.g., application and/or approval for Medicaid waivers, including their purpose); also important to include are negotiations with welfare and other pertinent State and local government departments/agencies to maximize benefits and available resources, and outreach to businesses and other public and private sector funding organizations.

Established linkages must be demonstrated with key State and local services and resource systems, such as Title V, Title XIX (Medicaid), Title XXI (State Child Health Insurance Program), WIC, Title X (Family Planning), Early Intervention, HIV/AIDS, Substance Abuse, Mental Health Programs, Enterprise Communities/Empowerment Zones, Federally funded community and migrant health centers, and Indian/Tribal Health Services.

6. Linkage to the State and Local Perinatal Systems

Factor IV. (Weight 10%): Evidence of support from and linkage to the State and local perinatal systems, as measured by:

A. The extent to which the project is linked to an existing perinatal system of care that enhances the applicant's infant mortality reduction program already in operation in the project area.

B. The extent of actual or planned involvement of the State and local MCH agencies and other agencies is clearly evident.

C. The extent to which the project is consonant with overall State efforts to develop comprehensive community-based systems of services, and focuses on service needs identified in the State's MCH Services Title V- Five Year Comprehensive Needs Assessment and Block Grant Plan.

In this section, applicants should briefly document active, functioning, collaborative relationships between the proposed project and any entities such as those cited below, especially those involving

State Title V MCH agency linkages.

Within each community, there is a system involving a broad array of providers and public and private agencies at various phases and at varying levels in the delivery of perinatal health care. (Perinatal is defined as the time period from preconception through the first year of life.) Healthy Start applicants need to receive support from and be linked to appropriate components of their State and local perinatal systems of care to contribute to each system's goal for the long term reduction in a community's infant mortality. Highlight in the narrative the relationships between the project and the perinatal providers and facilities identified in the needs assessment, Section B.1. Sample current formal agreements and letters of understanding pertinent to the proposed project may be included in Appendix B.

It is expected that the HSI projects will be linked with various State and local MCH activities or programs. This section of the narrative should accent those linkages. Of particular importance is close collaboration with the Medicaid and Title V agencies. Since many within the target population are Medicaid recipients or will be Medicaid or SCHIP eligible, and Medicaid financing of services (including possible development of program waivers) will be essential, projects must maintain early, consistent, and ongoing linkages to, and involvement with their State and local Medicaid and Title V MCH agencies in planning and operations. If not already involved, the successful applicant must develop a process for involving appropriate State or local MCH agencies, such as membership in the project consortium, and/or regular consultation throughout the planning and implementation of the project. Other relevant State agencies include those responsible for EPSDT, Title X Family Planning, State Children's Health Insurance Program (SCHIP), Administration on Children, Youth and Families (ACYF), Early Head Start, substance abuse, mental health, child welfare, education, early intervention, child care, and job opportunities. Linkage issues which might be addressed include waivers, Medicaid coordinated care, simplified eligibility applications, collaboration and/or co-location of services. Any relationships with other important programs such as HRSA/MCHB's Community Integrated Service System Program (CISS) and the Federally funded Enterprise Communities/Empowerment Zones should also be identified. The State Title V Director is an important resource for information on such programs (see http://www.mchb.gov for a listing). A sample of the documentation of these linkages or formal commitments by agencies to form these linkages should be placed in Appendix B.

Identify the perinatal and early childhood service needs identified in the State's MCH Services Title V-Five Year Comprehensive Needs Assessment and Block Grant Plan that are pertinent to the project. The State Title V Director is the resource for this information (see (http://www.mchb.gov). Identify how the models chosen for replication would further the State's MCH goals and how lessons learned from implementation of the models will be shared with the State, and other MCH providers in the State. If this information has been provided in other sections, it need only be cross-referenced here.

7. Consortium Model

Factor V. (Weight 15%): Structure and Role of Applicant's Consortium, as measured by:

A. The extent to which the consortium includes appropriate representation of project area consumers, providers, and other key stake holders.

B. The role and plan of action of the consortium in the implementation of the proposed project plan are adequately described.

The consortium is an advisory body expected to:

- Recommend policy for and contribute to the development of the application;
- Contribute to, review, and recommend approval of the organizational approach for assuring local determination and integration;
- Provide advice regarding program direction;
- Participate in discussions related to allocation and management of project resources;
- Have in place conflict of interest policies governing all activities
- Be aware of program management and activities such as data collection, monitoring and evaluation, public education, and assuring continuity of care; and
- Share responsibility for the identification and maximization of resources and community ownership to sustain project services beyond the project period.

The consortium must include representation that reflects a partnership of consumers, providers of services, community organizations and groups, both public and private, with a working interest, skills, or resources that can be brought to bear on the problem of infant mortality. The individual consortium members must have sensitivity to and understanding of the needs of the project area. The members of the consortium should feel they have a significant advisory role and commitment to the plan for project implementation. This can be facilitated through the participation of consumers, community leaders, and service provider representatives in developing the application. Those members of the consortium selected to represent an agency or group should have the authority to make decisions for the entity they represent.

Each member of the consortium must have the necessary expertise to responsibly provide advice regarding the needs and problems existing in the community and the proposed strategies for the preparation and implementation of the project plan. It **must include consumers, i.e., women of childbearing age who will be/are receiving project services** and ideally, at least one individual representing each of the following groups:

- Community/migrant health center(s);
- Private health care sector;
- State Title V agency;
- Medicaid agency;
- Local health department;
- Local elected official with health care responsibility in the political jurisdiction(s) in which the project area is located;
- Social services agency;
- Local business community;

- Religious organizations or associations;
- Community/civic organizations serving the project area; and,
- Enterprise Communities/Empowerment Zones, if appropriate.

In this section of the narrative, provide information on the

a. Consortium Membership:

Describe the consortium membership. Provide a complete list of consortium members and their representative agencies in the suggested format found in Attachment F. This should be placed in Appendix D of the application.

b. History of Consortium:

Highlight information with supplemental material, placed in Appendix D, which substantiates that the current consortium has been:

- in operation at least one year prior to the date of the application, and
- involved in activities focused on eliminating disparities in perinatal health (e.g., health fairs, early intervention) in the project area.

c. Role of Consortium

Delineate the anticipated role(s) the consortium will play in implementation of the HSI project. Discuss activities the consortium will implement which are specifically related to the proposed project, including the frequency of consortium meetings, public forums, and training/conferences.

d. Environment in which the Consortium Operates:

Include a succinct update on external factors/major community events which have significantly affected the consortium's MCH initiatives (e.g., mayoral/tribal elections, neighborhood issues, etc.).

8. Proposed Budget

Factor VI. (Weight 15%): The appropriateness of the budget, as measured by*:*

A. The extent to which the proposed budget is realistic, adequately justified, and consistent with the proposed project plan.

B. The extent to which the costs of administration and evaluation are reasonable and proportionate to the costs of service provision.

C. The degree to which the costs of each model are economical in relation to the proposed service utilization.

The budget must conform to the funding level instructions provided in this program guidance. Please note: A separate budget and SF 424A must be submitted for each of the four budget years of the project period. For the first budget year a very detailed budget justification is required. For subsequent years, estimations for project costs and any anticipated changes should be noted. Refer to Attachment B for detailed budget instructions. The PHS grant instructions require the

specification of budget items as well as a description and justification of these items in direct relationship to the project narrative. The budget justification for year one should appear directly after the SF 424A for year one. (See "General Information and Instructions for Grant Application Form PHS-5161-1", page 25) The line item amounts on the SF 424 and 424A must be inclusive of model-specific budgets (as noted in the instructions below), as well as overall administrative and management costs. Applicants should be aware that all models presented may not be funded, and in that case the estimated administrative and management budget may be reduced accordingly (see Attachments B-1, B-2 and B-3). It should be noted that the costs proposed in Section B of the SF 424A reflect only the Federal Healthy Start funds being requested; they should not include funding from other sources.

Where applicable, if any staff, equipment, activities, professional subscriptions or dues are shared with other programs (e.g., WIC, CISS, local or state funded programs) operated by the applicant, their costs should be prorated to the anticipated utilization for HSI's activities.

All project administration and evaluation costs should be assigned to the "Administration and Management" column of the proposed annual project budget. For the travel line item, all applicants should budget up to 10 person round-trips for attending DPSWH meetings in Washington, DC and other relevant events

Technical assistance can be obtained from either Healthy Start mentoring sites or from non-Healthy Start resources. To receive mentoring from approved Healthy Start Mentoring sites, recipients should budget for anticipated travel, per diem and accommodations only; the Mentor site providing the services is responsible for paying the staff member's salary for this activity. Mentor sites will provide at no cost one copy of any manuals, etc. Recipients will pay the costs of any additional copies. Proposed costs for technical assistance from non-Healthy Start sites, (e.g., travel, registration, consultant fees) should be included in the applicant's budget.

All evaluation costs should be shown on the appropriate line item (h-3 :Evaluation) of the administration and management column on the SF 424A, **Attachment B-3**.

Applicants must make every effort to build on and maximize existing resources available from other Federal, State, and local sources and private sector organizations, and to collect reimbursement from all relevant payers. Applicants may use sliding fee scales, as appropriate for added revenue, as long as they do not create any barriers to access; such projected revenue should be cited for each model/column in the line item #7,'Program Income' located at the bottom of the SF-424A form.

a. Model Specific Budget

For each model for which HSI funding is requested, a line item budget and budget justification is required. To assist with this effort, a suggested format and example, similar to the Standard Form 424A, has been provided in Attachments B-3 and B-4.

With the exception of administration and evaluation, costs directly associated with each model must be appropriately allocated to the specific model. The submitted budget

justification needs to be detailed enough to enable reviewers who may not be familiar with the applicant's State or local programs, funding sources, and limitations, to have a clear understanding of the proposed budget and its association with the model activities described in the project plan. The justification for each item in the budget shall show how the amount and type of item requested was determined. Each position (including contractor staff) should be justified in terms of the project activities and specified skills and/or experience. Similar justification should be provided for travel items, equipment, contractual services, supplies, and other categories.

Justification of contractual services shall include the purpose, scope, and projected cost of the subcontract. Itemized budgets are required for subcontracts. The derivation of travel costs includes person/position traveling, destination, duration, purpose, and associated costs for each proposed trip. Supplies shall be classified by appropriate categories (e.g., administrative or related to service provision).

Estimated costs should be pertinent and feasible for the proposed scope and anticipated utilization levels which the applicant has cited in the description of the model's component strategies.

Like all Healthy Start grantees, all applicants are required to be linked to the Internet, including access to E-mail; HSI grant funds may be used for such subscription/linkages. The Internet connection would enable participation in a ListServe for all Healthy Start projects, and many MCHB technical assistance resources as well as the MCHB homepage (http://www.mchb.gov) and/or the Healthy Start National Resource Center at http://www.healthystart.net. This service will facilitate timely and valuable sharing of information, and enable primary staff to query their peers and outside experts.

b. Economy of Model in Relation to Utilization

All costs should be realistic and reasonable in comparison to the proposed level of activity, particularly to the level of projected service utilization by the target population.

c. Proportional Administrative and Management Costs

Administrative and management (including program and fiscal management and local evaluation) costs must be included as part of the overall budget. Estimated costs for these areas need to be reasonable in comparison to costs associated with service provision. Applicants should be aware that all models for which funds are requested may not be funded, and that the overall budget of the projects may be reduced to correspond with the number and size of models funded, and reasonable administrative and management costs.

d. Indirect Costs

Indirect costs will be calculated at 10% of total direct costs or modified total direct costs which

ever is less, to stay within the total approved budget. A copy of the most recent negotiated indirect cost rate agreement should be included in the application.

ATTACHMENT A

ABSTRACT: FORMAT AND GUIDELINES

I. **Format:** The abstract, excluding the Text of Annotation, and Key Word List, must NOT EXCEED A FOUR PAGE description of your project. Format guidelines are as below:

A. Margins should be 1 inch at the top, the bottom, and both sides.

B. Use a standard (non-proportional) 12 pitch font or typeface, such as courier, per the publisher's requirement. Please use plain paper (not letterhead stationary or paper with borders or lines) and avoid "formatting" (do not underline, use bold type or italics, or

justify margi ns).

C. Capitalize only the first letter of principal words when filling in the lines at the top of the form. Be sure to include the area code with the telephone number, and the full mailing address (including street and/or P.O. Box) with the zip code.

D. Type section headings in all capital letters followed by a colon and two spaces. Begin the narrative immediately after the two spaces. Do not indent paragraphs, but do double-space between them. Sections should be single-spaced.

E. In addition to the original copy of the Abstract in the application, send a second copy and a disk copy in a separate envelope with the Grant (See Chapter II " General Instructions"). Please indicate the type of software and operating system used (e.g., Word Perfect (IBM or Mac), Word (IBM or Mac), MacWrite) on the envelope and/or disk label.

F. Project Identifier Information

Project Title:	List the title as it will appear
Project Number:	Leave blank; Number will be assigned when grant is awarded
Project Director:	The name and degree(s) of the project director as listed on the grant
Contact Person:	The person to be contacted by those seeking information about your project
Awardee:	The organization which receives the grant
Address:	The complete mailing address
Phone Number:	Include area code, phone number, and extension if necessary
Fax Number:	Include fax number
E-mail Address:	Include electronic mail address (Internet, HandsNet, etc.)
World Wide Web Address:	If applicable, include the address for your project's World Wide Web site on the Internet
Project Period:	Include the entire proposed funding period, not just the one-year budget period

II. **Abstract Narrative:** The abstract is an independent document which is disseminated together with all MCHB abstracts. Therefore, no reference to other sections of the application should be made in the abstract narrative. Emphasize the project's uniqueness in this brief report using the following outline:

A. PROBLEM: Briefly describe the project area; the prevalence of problems related to infant mortality in your project area; its pertinent racial/ethnic disparities; and the population to be addressed. Identify issues related to gaps in services to improve quality of and access to the perinatal delivery system. **State by ethnic and racial group, the project's 1995-1997 average and latest available rate for infant, neonatal and post- neonatal mortality; the proportion of low birthweight infants; and the number/percentage of live births.** Also provide the number/percentage of births to adolescents under 18 years, the proportion of children under two with age appropriate immunization levels, and the percentage of children under 18 years of age with family incomes below the Federal Poverty Level (for 1990 or latest year available). The years for each statistic must be identified. Also, 1998 and 1999 data should be provided if such verifiable (non-provisional) information is available.

B. GOALS AND OBJECTIVES: Identify the major goals and objectives for the project period including those which address gaps in quality and access to the perinatal system of care in the community. Summarize, from the application narrative, specific performance-based objectives for each service model. Typically, projects define the goal in one paragraph and present the objectives in a numbered list.

C. METHODOLOGY: Describe each proposed model and highlight activities which will be used to attain the goals and objectives of that model. Comment on innovation, cost, and other characteristics of the methodology. Activities discussed in this section should clearly define the contributions and roles of the consortium, consumers, providers and other relevant parties in developing the program.

D. COORDINATION: Describe the coordination planned and implemented with appropriate State, local health and other key organizations in area(s) to be served by the project. Emphasize the project's communications and collaborations with the State Title V MCH agency. Define the role the consortium has had in the development of this project. Discuss the successful collaborative activities and other accomplishments related to identification of resources by the applicant.

E. EVALUATION: Briefly describe the evaluation methods which will be used to assess the effectiveness and efficiency of the project in attaining its objectives. Methods for data collection and analysis should be clearly defined and incorporate the selected model-specific performance indicators and commonly used analytical methods.

III. **Guidelines for Preparing Your Annotation:** Prepare a three-to-five sentence description of your project which identifies the project's purpose, the needs and problems which are addressed, the goals and objectives of the project, the activities which will be used to attain the goals, and the materials

which will be developed.

IV. **Key Words:** Key words are the terms under which your project will be listed in the subject index of the abstracts book. Select significant terms which describe the project, including populations served.

A list of key words used to classify all active MCHB projects is included in Attachment A-1. Choose key words from

this list when describing your project.

V. **Submitting Your Abstract and Annotation:** The National Center for Education in Maternal and Child Health (NCEMCH) will prepare the submitted abstract for publication once the application is approved. It is therefore very important to follow the instructions for submission of the abstract very carefully.

Attachment A 1

LIST OF KEYWORDS

A list of keywords used to describe MCHB-funded projects follows. Please choose from this list when selecting terms to classify your project.

Please note that this list is constantly under development: new terms are being added and some terms are being deleted. Also, this list is currently being revised so that it will match more closely the approved list of keywords in the MCH Thesaurus. In the meantime, however, this list can be used to help select keywords to describe MCHB-funded projects.

If no term on this list adequately describes a concept which you would like to convey, please select a term which you think is appropriate and include it in your list of keywords.

Access to Health Care
Adolescent Health Programs
Adolescent Nutrition
Adolescent Parents
Adolescent Pregnancy
Adolescent Pregnancy Prevention
Adolescent Risk Behavior Prevention
Adolescents
African Americans
AIDS
AIDS Prevention
Alaska Natives
Anemia
Appalachians
Asian Language Materials
Asians
Asthma
Audiovisual Materials
Baby Bottle Tooth Decay
Back to Sleep
Bacterial Vaginosis
Battered Women
Behavior Disorders
Bereavement
Bilingual Services
Birth defects
Bonding
Breast Pumps
Breast feeding
Cambodians
Caregivers
Case Management
Cerebral Palsy
Child Abuse
Child Abuse Prevention
Child Care
Child Neglect
Child Nutrition
Child Sexual Abuse
Children with Special Health Needs
Cleft Lip
Cleft Palate
Cocaine
Community Based Health Education
Community Based Health Services
Community Development
Community Integrated Service System
Community Participation
Comprehensive Primary Care
Congenital Abnormalities
Consortia
Continuing Education
Continuity of Care
Cost Effectiveness
Counseling
Cultural Diversity
Cultural Sensitivity
Curricula
Data Systems
Databases
Deafness
Decision Making Skills
Delayed Development
Dental Treatment of Children with Disabilities
Depression
Developmental Disabilities
Developmental Screening
Dietitians
Dispute Resolution
Dissemination

Down Syndrome
Early Childhood Development
Early Intervention
Emergency Medical Services for Children
Enabling Services
Failure to Thrive
Families
Family Centered Health Care
Family Centered Health Education
Family Characteristics
Family Planning
Family Therapy
Family Support Services
Family Violence Prevention
Fathers
Feeding Disorders
Fetal Alcohol Syndrome
Formula
Foster Children
Genetic Counseling
Genetic Disorders
Genetic Screening
Gestational Weight Gain
Grief
Hawaiians
Head Start
Health Care Financing
Health Care Utilization
Health Education
Health Insurance
Health Maintenance Organizations
Health Professionals
Health Promotion
Healthy Mothers Healthy Babies Coalition
Healthy Start Initiative
Healthy Tomorrows Partnership for Children
Hearing Screening
Hemophilia
Hepatitis B
High Risk Pregnancy
Hispanics
HIV
Hmong
Home Visiting for At Risk Families
Home Visiting Services
Homeless Persons
Hospitals
Hypertension
Illnesses in Child Care
Immigrants
Immunization
Incarcerated Women
Incarcerated Youth
Indian Health Service
Indigence
Infant Health Care
Infant Morbidity
Infant Mortality
Infant Mortality Review Programs
Infant Nutrition
Infant Screening
Infants
Injuries
Injury Prevention
Intensive Care
Interconceptional Care
Interagency Cooperation
Interdisciplinary Teams
Iron Deficiency Anemia
Iron Supplements
Language Barriers
Language Disorders
Laotians
Lead Poisoning
Leadership Training
Learning Disabilities
Literacy
Local Health Agencies
Local MCH Programs
Low Birthweight
Low Income Population
Lower Birthweight
Males
Managed Care
Marijuana
Maternal and Child Health Bureau
Maternal Nutrition
MCH Research
Media Campaigns
Medicaid
Medicaid Managed Care
Medical Home
Mental Health
Mental Health Services
Mental Retardation
Mexicans
Micronesians
Migrants
Minority Groups
Minority Health
Mobile Health Units
Morbidity
Mortality
Multiple Births
Native Americans
Needs Assessment
Neonatal Intensive Care
Neonatal Mortality
Neonates
Neurological Disorders
Newborn Screening
Nurse Midwives
Nurses
Nutrition

Obstetricians
One Stop Shopping
Oral Health
Otitis Media
Outreach
Pacific Islanders
Paraprofessional Education
Parent Education
Parent Networks
Parent Professional-Communication
Parent Support Groups
Parent Support Services
Parental Visits
Parenting Skills
Parents
Patient Education
Pediatric Dentistry
Pediatric Intensive Care Units
Pediatric Nurse Practitioners
Pediatricians
Peer Counseling
Peer Support Programs
Perinatal Health
Physical Disabilities
Preconception Care
Pregnant Adolescents
Pregnant Women
Prematurity
Prenatal Care
Prenatal Screening
Preschool Children
Preterm Birth
Preventive Health Care
Primary Care
Professional Education
Public Health Education
Public Health Nurses
Public Private Partnership
Puerto Ricans
Quality Assurance
Regionalized Care
Reimbursement
Repeat pregnancy prevention
Research
Residential Care
Runaways
Rural Population
Safety in Child Care
Safety Seats
School Age Children
School Dropouts
School Health
School Nurses
Schools
Screening
Seat Belts
Self Esteem
Service Coordination
Sex Roles
Sexual Behavior
Sexuality Education
Sexually Transmitted Diseases
Shaken Infant Syndrome
Siblings
Sickle Cell Disease
Smoking During Pregnancy
Social Work
Southeast Asians
Spanish Language Materials
Special Education Programs
Specialized Care
Specialized Child Care Services
Speech Disorders
Spina Bifida
Spouse Abuse
Standards of Care
State Health Agencies
State Systems Development Initiative
Stress
Substance Abuse
Substance Abuse Prevention
Substance Abuse Treatment
Substance Abusing Pregnant Women
Substance Exposed Children
Substance Exposed Infants
Sudden Infant Death Syndrome
Support Groups
Tertiary Care Centers
Third Party Payers
Title V Programs
Toddlers
Training
Transportation
Trauma
Twins
Uninsured
Urban Population
Vietnamese
Violence
Violence Prevention
Waiver 1115
Well Baby Care
Well Child Care
WIC
Youth in Transition

ATTACHMENT A 2

HEALTHY START INITIATIVE - PHASE II
SAMPLE ABSTRACT

Project Title:	Healthy Start/Urban City (HEALTHY START/UC)
Project Director:	Michael Briggs, M.S.W.
Contact Person:	Michael Briggs
Applicant Agency:	Urban City Health Association, Inc. (UCHA)
Address:	3020 Jones Street, Room 347
	Urban City, Nowhere 00000
Phone Number:	(000) 123-4567
Fax Number:	(000) 456-7891
E-mail Address:	hsuc1@aol.com
World Wide Web Address:	www.example@AHHS.com
Project Period:	6/1/00-5/31/04

PROBLEM: The three densely populated urban communities that make up the Healthy Start/ Urban City (HEALTHY START/UC) project area--Greenbed, South Central, and Terrace Heights--are the sites of the Nation's deepest and most intractable poverty. These communities are also known for their cultural diversity and rich histories. In 1990, 175,000 people lived in these three service areas. In 1990 more than half of children under 18 (51.0%) lived in families whose incomes were at or below the poverty level, and nearly one-third of the families received public assistance. Almost one-third of all the residents of these communities (54,250) were women of childbearing age (aged 10-44). Public and privately funded providers in the project area offer a variety of health and social services, yet many pregnant women are excluded from the service net. Data from 1995-1997 show that one-third (33.9 percent) of women giving birth in the project area received no prenatal care; 1998 data shows no real improvement. Similarly, infants often do not receive routine well baby care as is reflected by lower immunization levels; in 1998, 87% of children younger than two in the project area were appropriately immunized.

In 1998, the infant mortality rate (IMR) was higher, 17.3 (22.5 for African Americans, 12.6 for Whites, and 15.3 for Hispanics) than it had been in 1995-1997 when it averaged 16.6 (22.3 for Blacks, 12.7 for Whites, and 15.0 for Hispanics). The neonatal mortality rate (NMR) for 1998 was 8.8 (12.6 for Blacks, 8.3 for Whites, and 8.7 for Hispanics) which shows some improvement over the average 1995-1997 rate of 9.1 (14.8 for Blacks, 6.2 for Whites and 6.7 for Hispanics.) It should be noted that while there was some improvement in NMR for Blacks, this was not true for the other two population groups in the project area. Post-neonatal mortality rates were slightly higher in 1998 (8.7) for all three communities than in 1995-1997 (7.6): in 1998 the rate was 9.7 for Blacks, 6.2 for Whites and 6.6 for Hispanics; the three-year average from 1995-1997 for Blacks was 7.5, for Whites 6.5, and for Hispanics 8.3.

The proportion of low birthweight babies for 1998 of 11.7 (16.2% for Blacks, 5.9% for Whites, and 10.5% for Hispanics) was also slightly higher than the 1995-1997 average percent of 10.2 (15.6% for Blacks, 6.7% for Whites and 10.6% for Hispanics). The number of live births in the project area for 1998 was 4691 (1467 for Blacks, 2348 for Whites, and 550 for Hispanics.) This compares with the 1995-1997 average of 4105 (1284 for Blacks, 2055 for Whites, and 481 for Hispanics.)
The HEALTHY START/UC needs assessment showed that health care and social service providers in the project area are short staffed, overburdened and often perceived by residents to be insensitive to their needs and problems. Services are often fragmented which has resulted in women and infants being lost to follow up. A high proportion of births occur to women under the age of 18 (8.7% in 1998) who are not prepared for parenthood or to older women stretched to the limit by other responsibilities. Drug use is pervasive, and prevention and treatment programs are scarce. Sexually transmitted diseases, including HIV, are epidemic. Housing is inadequate and dangerous. Child care is difficult to obtain, and domestic violence is a hidden problem and probably a significant factor for poor birth outcomes. Given all the burdens faced by women and their families, infant mortality is not always perceived as a priority. The challenge for the HEALTHY START/UC project is not only to provide and coordinate services, but to mobilize communities to take ownership of the problem and to design and implement programs that they themselves feel have the best chance of success.

GOALS AND OBJECTIVES: In an effort to address some of the more critical needs identified by the needs assessment and reduce factors associated with high infant mortality rates, the HEALTHY START/UC project has identified three major goals. These goals include: 1) to improve health and social services care coordination; 2) to enhance provider sensitivity to major cultural health and belief practices of the community; and 3) to increase identification and referral of domestic violence. Each goal relates to one of the models described under "Methodology" below and has two or three objectives.

To improve health and social service care coordination the project proposes to: 1) Complete initial risk assessments on all clients, both prenatal women and infants, and assist 90% of those needing special referral services (i.e. smoking cessation or Early Intervention) to obtain follow up by 5/31/04; 2) Assure that 90% of pregnant women who receive HEALTHY START/UC case management services have adequate health care (defined by trimester of entry into HEALTHY START/UC) by 5/31/04; and 3) Provide home visits within 72 hours after birth and hospital discharge to 100% of infants born to mothers with a risk status of 8 or higher by 5/31/04.

Enhanced provider sensitivity to major cultural health and belief practices of the community will be considered successful if the project is able to: 1) Reduce by 20% prenatal and initial pediatric (infant) "no show" rates at all city and community clinics within the project area by 5/31/04; 2) Increase to 75% the proportion of prenatal women at four OB/Gyn clinics who seek post partum care within six weeks after delivery, by 5/31/04; and 3) Complete cultural sensitivity training for 75% of providers by 5/31/04.

To improve identification and referral of domestic violence, the project proposes to: 1) Train 90% of prenatal and pediatric direct care providers serving the project area by 05/31/04; and 2) Screen 95 % of prenatal women and parents of infants at the four project area clinics/agencies by 5/31/04.

METHODOLOGY: The major thrust of the HEALTHY START/UC project will be to expand existing services in all three communities to encourage women to seek early and regular prenatal care, to increase provider sensitivity to cultural diversity and the resource needs of families living in poverty, and to enhance domestic violence identification and referral. The first model, case management for pregnant and parenting women, will address system fragmentation and encourage women to learn more about prenatal and/or infant care. Clients (pregnant women and infants) who are identified by health or social service providers, homeless shelters, churches or others in the community (including consortium members) will receive a risk assessment; those who score in the top 50% for medical or social risk factors will be eligible to participate in case management services. Those who are at lower risk will be referred to health care agencies if they have not initiated prenatal or infant health care. A major focus of these services will be to provide health education on prenatal and/or infant care as well as enhancing parenting skills for families with infants. Clients will learn more about the basics of managed care, resource availability, and how to access these resources. A primary focus for the case manager will be assuring that each client receives regular health care and has assistance with transportation as needed. Major case management providers in the area will collaboratively establish case management protocols based on risk levels of clients, conduct joint staffing training, and recruit the additional case managers to serve the target population.

The second model will focus on cultural sensitivity and resource availability training for providers. As a result of the needs assessment, several providers have indicated they are not familiar with some of the dominant cultures in each of the three communities. Individual beliefs and practices as well as the nature and extent of family support are often associated with client culture(s), and these in turn have an effect on the health-seeking behavior (commonly called "compliance" by health care professionals) of families in these communities. With guidance from the consortium, HEALTHY START/UC will offer a series of in-service sessions at 10 health and social service provider agencies. The consortium will develop a resource guide, with assistance from project staff, which will be handed out and utilized at these training sessions.

Domestic violence may involve spouse and/or child abuse. It is considered to be a significant factor associated with both fetal and infant mortality. The third model, domestic violence identification and referral, will involve development of a uniform domestic violence risk assessment tool, implementation of this tool at many major health and social service agencies in the project area, and identification of treatment resources available. In conjunction with key health and social service providers and clergy on the consortium, locally available experts in the field will develop a simple but effective domestic violence assessment tool. Once the tool has been developed, this team will help train providers of at least seven health or social service agencies on its importance and use. As part of this training, a list and brief description of referral agencies will be provided.

COORDINATION: The city-wide HEALTHY START/UC consortium, a group of more than 50 public and private agencies has been in existence for more than four years. In the past, a major focus for the consortium has been primary education (including development of a health curriculum for the schools) and safety, and to some extent, community violence. Increasing concerns about domestic and community violence, the addition of UC Department of Public Health (UC DPH) representation on the consortium

within the past year, and results of the needs assessment have indicated that infant mortality is also significant problem which should be addressed in a more comprehensive manner and with greater resources than have previously been available. To ensure adequate community representation, membership includes residents and consumers from each community, a representative from the UC DPH and the Department of Education, staff from health clinics and social service agencies, clergy, local business representatives and other key community leaders. The consortium reviewed results of the needs assessment and assisted with the prioritization of problems to be addressed in the application. Executive board members reviewed the application prior to submission. Data from the needs assessment and project plans have been shared with the State Title V Director who has expressed much interest in all three models, particularly development and implementation of the domestic violence risk assessment tool. Discussions have been initiated with two local corporations, one of which has a large number of minimum wage employees, regarding sustaining and expanding Models 1 and 3. Within the next year, the consortium plans to add health maintenance organization and university professional staff representatives.

EVALUATION: The evaluation will involve analysis of data from two different data processes. For the first data process, data collection will focus on variables related to the objectives identified above. Data collection for Model 1 (case management) will be done exclusively by case managers and/or their data collection staff who will obtain written client consent at the time of the initial risk assessment. For the second process, data collection for the other two models will involve a random sampling of appropriate clinic records at the participating clinics or agencies. For these models, agency or clinic participation in any of the Healthy Start Initiative - Phase II activities will involve a signed Memorandum of Agreement between UCHA and each clinic to participate in the data collection process.

Annotation:

To address some of the more critical needs of the Urban City maternal and infant population, and reduce factors associated with high infant mortality rates, the HS/UC project and its consortium have identified three major goals. These goals include: 1) to improve health and social services care coordination; 2) to enhance provider sensitivity to major cultural health and belief practices of the community; and 3) to increase identification and referral of domestic violence. The consortium will work with project staff to help assure that objectives and goals are met.

Key Words:

African-American/Black; Case Management/Care Coordination; Consortium; Cultural Sensitivity; Data Collection; Domestic Violence; Domestic Violence Screening Tool; Health Education; Healthy Start Initiative; Hispanic/Latina/Latino; Immunization Levels; Infant Health Care; Infant Mortality; Low Birthweight; Managed Care; Needs Assessment; Neonatal Mortality Rate; Objectives; Parenting Skills; Pregnant Women; Post-Neonatal Mortality Rate; Provider Training; Resource Guide; Risk Assessment; White; Women of Childbearing Age.

ATTACHMENT B

GUIDELINES FOR BUDGET AND BUDGET JUSTIFICATION

I. General:

In addition to the enclosed "DHHS - PHS Grant Application, Form PHS 5161-1" (Instructions) and the general information presented in budget section of Chapter III of the guidance, the following specific instructions are provided to assist all applicants for Healthy Start grant applicants prepare their budget proposal and budget justifications.

Instructions for the required multi-year budget submission have been integrated into this attachment. Funding for each year of the project period is based upon the availability of funds and satisfactory programmatic progress of the grantee. The submitted budget for the second and subsequent years of the project period can be estimations. (Note: Rebudgeting of Healthy Start Initiative funds must comply with Grants Management Policy and any conditions included in the Notice of Grant Award)

The budget justification requires the applicant to show how specific line items support the project operations. All costs in the submitted budget for each year should be reasonable, necessary and consistent with the project's proposed models, objectives and activities. Because of its anticipated length, the narrative Budget Justification will not be counted toward the page limit of the application, but should be placed in front the Project Abstract and have **sequentially numbered** pages.

II. Project Period and Budget Period Specifications for Healthy Start Initiative- Eliminating Racial/Ethnic Disparities:

"Project Period: The total time for which support of a discretionary project has been programmatically approved. A project period may consist of one or more budget periods. The total project period comprises the original project period and any extensions."

"Budget Period: The interval of time (usually 12 months) into which the project period is divided for budgetary and funding purposes."
(Ref.: PHS Grants Policy Statement, April 1, 1994, pp. 2-3 and 2-1)

Project Period: June 1, 2000 through May 31, 2004.

Maximum Annual Budget: $500,000 pending availability of funds

Budget Period time frames: (A separate line item budget (SF424A) and budget justification will need to be submitted for each of the following budget periods):

BY 00/01 Budget Period: June 1, 2000 through May 31, 2001;
BY 01/02 Budget Period: June 1, 2001 through May 31, 2002;
BY 02/03 Budget Period: June 1, 2002 through May 31, 2003; and
BY 03/04 Budget Period: June 1, 2003 through May 31, 2004.

Proposed Budgets for this specific competition must include the required models of Consortium, and Case Management; other models may be considered based on need and availability of funds.

III. Funding Utilization and Budgeting Requirements: Applies to all applicants:

No Supplantation: Healthy Start Initiative funds may only be used to supplement and not supplant other Federal or non-Federal funds that would otherwise be made available to the project.

Shared Staffing: Applicants proposing to utilize the same director or contractual staff across multiple grants (e.g., CISS, Healthy Start Initiative, State Title V block grant) should assure that the combined funding for each position does not exceed 100% FTE. If such an irregularity is found, funding will be reduced accordingly.

Cash Stipends/Incentives: Funds cannot be utilized for cash stipends/incentives to clients to enroll in project services. However, funds can be used to facilitate participation in project activities (e.g. day care/transportation costs/tokens to attend prenatal clinic visit), as well as for services rendered to the project (e.g., adolescent peer mentors).

Purchase of Vehicles: Because of limited project period of the Healthy Start Initiative grants, projects should not allocate funds to buy vehicles for the transportation of clients and should instead lease vehicles or contract for these services.

No Lobbying: Healthy Start Initiative Funds cannot be used to lobby the Executive or Legislative branches of the Federal Government in connection with the Healthy Start Initiative. All applicants should review and sign Page 21 of PHS 5161-1 (Rev. 6/99) certifying that project funds are not being used for lobbying activities. Pursuant to Section 1352 of Title 31, United States Code, all grantees must now disclose any lobbying undertaken with non-Federal (non-appropriated funds). If non-Federal funds are being used for lobbying activities, grantees must disclose this information by completing Standard Form LLL "Disclosure of Lobbying Activities" Page 21 of PHS 5161-1 (Rev. 6/99).

IV. Healthy Start Initiative: Overall Project and Model-specific Budgets:

Applicants must submit *BOTH* total and model-specific budgets for each budget year of the project period according to the instructions below.

A. SF 424A (Section A, C, D, E, F)

The applicant must complete Sections A, C, D, E and F of the SF 424A budget form

following the directions found in the PHS 5161-1 Instruction Booklet.

B. SF 424A (Section B)

SF 424A Section B should **not** be completed until the model-specific budgets described below are completed. During the application review process, the funding level for each approved application (and each HEALTHY START approved model) will be determined.

The model-specific budgets should be detailed on a separate budget form (sample included in **Attachment B-2**) for each budget year. To facilitate the review and funding determinations, the proposed model-specific budgets must have stand alone cost estimates with accompanying line item justification, including cost breakdowns. The project's budget should have a column for each of the following:

- project-wide Administration and Management/Evaluation costs
- the Organizational Model-Consortium
- each of the proposed service models.

The model-specific budget should be attached to the SF 424A.

The "Total" column in **SF 424A Section B** should reflect the grand total of all administration/management/evaluation and model-specific budgets by object class category, as detailed above. The other columns in Section B should <u>not</u> be completed; see the sample in **Attachment B-2.**

V. OBJECT CLASS CATEGORIES (Line 6): The following PHS Instructions for Form 424A, "Section B - Budget Categories, (line 6). Object Class Categories" have been clarified.

A. Personnel: The salaries and wages of <u>only</u> those project staff <u>directly</u> employed by the grantee agency should be reflected in this object class category and entered on line "a-2: Personnel: All Others". The total costs (including local travel) for those project staff hired by the applicant agency as consultants or through individual or agency contracts should be itemized under the appropriate object class category, "Consultant Costs" (see Item 3 below) or "Contractual" (see Item 10 below).

For all applicant agency staff involved in the project, list each position with annual salary level and percentage of full time equivalency (FTE) on Healthy Start Initiative programs on the SF 424A Supplement - Key Personnel Form found in Attachment B-1. In listing the positions on this form, provide the name and degrees (as appropriate) of the incumbent if the position is filled (e.g. John Doe, M.S.W.), and vacant, (e.g., "vacant - PHN") if the position is new or not filled as of the date of application submission. If the project has multiple employees in both the same position and same % FTE (e.g. full-time outreach workers), enter the number

of positions filled on one line and the number of positions vacant on the subsequent line (e.g., line 1: 10 outreach workers [7.5 FTE] filled...., line 2: 5 outreach workers [3.75 FTE] vacant...)

The Budget Justification narrative should include a succinct description of the specific role and activities of each position funded by the proposed project. Position descriptions, along with a curriculum vitae (not to exceed 2 pages) for all key staff positions (i.e., Project Director, Chief Financial Officer, Director of Local Evaluation) for which grant support is requested, must be included.

Under Personnel category on the budget form , there are 2 new lines, "Mentoring", and "All Other". All Healthy Start Initiative Mentoring projects are to provide cost estimates for both lines. All other Healthy Start Initiative applicants should only provide personnel costs under the row "All Other".

B. Fringe Benefits: Costs should be calculated using the applicant agency's formally established policy. The Budget Justification narrative should indicate the numerical rate used by the applicant agency.

C. Travel: This category should be divided into local and out of area/long distance travel costs for grantee agency staff only; travel costs for consultant or contractors should be included in those corresponding lines (i.e., 'consultant', 'contractual'). For local travel, include mileage reimbursement rate, and estimates of mileage, public transportation fares, and number of staff to which this applies. For <u>each</u> proposed long distance trip, the budget justification must provide the trip's purpose and destination, and the estimated unit cost for: a) transportation, b) rate of per diem (meals and lodging), and c) the number of persons and duration of travel.

The travel budget should include proposed trips to conferences/meetings, including the mandatory MCHB sponsored grantee meetings in Washington, D.C. Please specify the number of trips, destinations, duration and type of conference/meetings up to a maximum of 10 person trips.

D. Equipment: Any durable good having a unit cost in excess of $5,000 is considered equipment. items having a smaller unit cost should be placed under "e: Supplies" on the SF 424A form. In the budget justification, describe the equipment by individual item, unit cost, quantity, and physical location of proposed equipment (e.g., grantee, Healthy Start Initiative service site, subcontractor). If the equipment is to be shared by multiple programs, (e.g., Healthy Start, WIC, Family Planning) within an agency, the proposed costs should be prorated across the involved programs, and described as such in the budget justification.

E. Supplies: A guideline of $500 per full-time project employee per year can be used to estimate the cost for office supplies. For other supplies, describe types and costs (e.g.,

public information materials, computer items under $5000 unit cost, and clinic supplies). If a "Supplies" item is to be shared by multiple programs, (e.g., Healthy Start, WIC, Family Planning) within an agency, the proposed costs should be prorated across the involved programs, and described as such in the budget justification.

F. Contractual: A budget for each contractor or sub-contractor, prepared and justified using these same instructions (including indirect costs), should be included in line f-1 or f-2, under 'Contractual'. The figures under these lines in the first column, "Administration and Management" should reflect all management related contracts and consultants except for those connected to the project's evaluation activities; these latter costs will now be inserted in the new budget line, "h-3. Evaluation". It must be emphasized that PHS grant regulations permit grantees to use funds for contracts and subcontracts but not for subgrants.

Consultants should also be included in this line item, but they should be listed separately. Detail the hourly rate, and estimated total number of hours needed; the justification should include the type of consultant services needed, and role the consultant(s) will play in the project activities.

G. Construction (Alterations and Renovations): Construction will not be an allowable cost on Healthy Start Initiative grants; however, for alterations and renovations refer to PHS Grants Policy Statement, (April 1, 1994) pp. 7-2, -3, and -4 for guidelines.

H. Other:

H-1 Other Misc. Costs Describe each item with itemized associated costs.

Examples:

- Rent/lease: include rate per square footage, number of square feet and duration of lease; provide estimates to demonstrate that the rate is within the current market range for a facility in that community.
- Maintenance agreements: identify item and cost;
- Meetings (e.g., health fairs, consortium meetings): identify costs, frequency, purpose and estimated number of participants;
- Similar costs proposed for a contractor should NOT appear in the 'Other' category, but rather as part of that contractor's budget, and subsumed under the 'Contractual' object class category (item 6).
- Internet Access subscriptions/setup (Required);
- Professional organization dues, related to the project;

H-2 Patient Care: Patient Care should also be included in the 'Other' category. Justification should include unit costs per visit, test, and medication per client, and the anticipated number of clients for each type of service. The budgeted costs for Patient Care, either directly or contractually provided, cannot exceed current reimbursement rates of Medicaid, Blue Cross/Blue Shield, or other common insurance carriers. Healthy Start Initiative funds should be the last fiscal resource for care services; if a

patient is insured or eligible for third party reimbursement, the project and all its contractors must bill/utilize those resources first. Any rebudgeting out of Patient Care costs must have prior PHS approval.

- In-patient - For Healthy Start Initiative, substance abuse treatment is the only allowable in-patient care item.
- Out-Patient - All reasonable ambulatory costs directly related to project services incurred under the limitations described above in this section are allowable.

H-3. Evaluation: All costs related to the project's evaluations activities should be estimated in this new line item, and only under the Administration and Management column. The budget justification narrative should delineate the costs in terms of contracts, consultants, supplies, travel, etc.

H-4. Mentoring: Does not apply to applicants in this competition.

I. Total Direct Charges: Total all line item costs of the categories above.

J. Indirect Charges: For Indirect Costs, see Instructions in PHS 5161-1 (dated 6/99), page 11. Please note that if indirect costs are requested, the grantee must submit a copy of the latest negotiated rate agreement (on same pages). The indirect costs rate for universities/educational institutions refers to the "Other Sponsored Program/Activities" rate and not the research rate.

It should be noted that Healthy Start Initiative traditionally has recommended that indirect costs not exceed 10% of the project's total budget.

K. Total Costs (by Model): List the total costs by proposed model (column).

VI. Estimated Program Income:. Program Income is income earned by a grantee from activities, all or part of which are borne as direct grant costs (see PHS Grants Policy Statement, pp. 8-10). Only Program Income which the grantee agency anticipates receiving during the proposed budget period is to be reported on this form; program income generated by contractors should not be reported. Examples of program income include:

- fees earned from services performed under the project;
- third party reimbursement and patient payment for medical or other services, such as payments from insurance carriers and patient sliding scale fees; and,
- funds generated by the sale of commodities, such as training manuals and health education materials.

Reminder: The "Total" column in **SF 424A Section B** should reflect the grand total of all administration/management/evaluation and model-specific budgets by object class category, as detailed above. The other columns in Section B should not be completed; see the sample in **Attachment B-2.**

ATTACHMENT B-1

SUPPLEMENT TO SECTION F of FORM 424A
KEY PERSONNEL

NAME AND POSITION TITLE	ANNUAL SALARY	NO. MONTHS BUDGET	% TIME	TOTAL AMOUNT REQUESTED
	1/1/00	1/2/00	1/3/00	1/4/00
$			$ %	
FRINGE BENEFIT				
(Rate ___)	Total			

SAMPLE ATTACHMENT TO SECTION B, SF 424A
HEALTHY START INITIATIVE - PHASE II BUDGET SUMMARY

Object Class Categories	Administration and Management*	Organizational Model Consortium	Service Model Case Management	Outreach (Optional Model)	Enhanced Clinical Services (Optional Model)	Total Costs
ersonnel	$56,000	$16,000	$155,000	$35,000	$31,000	$293,000
1. Mentoring	$6,000					
2. All Others	$50,000	$16,000	$155,000	$35,000	$31,000	
inge Benefits	$13,440	$3,840	$37,200	$8,400	$7,440	$70,320
avel	$5,000	$1,400	$28,000	$3,000	$1,200	$38,600
quipment	$10,000		$24,000			$34,000
ıpplies	$4,000	$500	$98,000	$8,200	$6,500	$117,200
ontractual:						$51,300
1. Contractors	$7,000	$300	$14,000	$10,000	$15,000	
2. Consultants		$3,000		$1,500	$500	
onstruction	$5,000		$9,000			$14,000
ther						$298,800
Other Misc. Costs	$63,000	$2,500	$14,000	$28,400	$26,400	
Patient Care: Inpatient			$4,000		$24,000	
Outpatient			$68,000		$15,000	
Evaluation	$50,000					
Mentoring	$3,500					
otal Direct Charges Costs	$216,940	$27,540	$451,200	$94,500	$127,040	$917,220
direct Charges (Costs) **	$36,332					$36,332
otals (sum 6j and 6k)	$251,000	$27,540	$451,200	$94,500	$127,040	$951,280
st. Program Income			$60,000	$825	$51,000	$111,825

* This column should address project-wide, non-model specific costs for administration and management. See definition of allowable administration costs in Attachment A.

** For Indirect Costs, see Instructions in PHS 5161-1 (dated 6/99), p. 11

SAMPLE ATTACHMENT TO SECTION B, SF 424A

HEALTHY START INITIATIVE - PHASE II BUDGET SUMMARY

OBJECT CLASS CATEGORIES	ADMINISTRATION & MANAGEMENT*	ORGANIZATION MODEL CONSORTIUM	SERVICE MODEL CASE	OUTREACH PROGRAMS (Optional)	ENHANCED CLINICAL SERVICES	TOTAL COSTS
ersonnel						
1. Mentoring						
2. All Others						
ringe Benefits						
ravel						
quipment						
upplies						
ontractual:						
1. Contractors						
2. Consultants						
onstruction						
ther						
Other Misc. Costs						
Patient Care: Inpatient						
Outpatient						
. Evaluation						
. Mentoring						
otal Direct Charges Costs						
direct Charges (Costs) **						
otals (sum of 6j and 6k)						
st. Program Income						

* This column should address project-wide, non-model specific costs for administration and management. See definition of allowable administration costs in Attachment A.

** For Indirect Costs, see Instructions in PHS 5161-1 (dated 6/99), p. 11.

Attachment C

INSTRUCTIONS FOR COMPLETING THE APPLICATION

A. Suggestions for Preparing the Application

In evaluating the applications, reviewers will use only the information presented in the application to assess the applicants response to the Review Factors and Criteria. It is essential that the application and responses to the Review Factors and Criteria are clear, complete and adequately supported by necessary data, as appropriate.

B. Format and Style

This section provides detailed instructions for formatting and organizing the grant application. A clearly written and easy-to-read grant proposal should be the goal of every applicant, since the outcome of the review process depends on information provided in the application narrative. Therefore, MCHB urges all applicants to develop their applications with the following**:**

- Correct grammar, spelling, punctuation, and word usage.
- Consistency in style. (e.g., The Elements of Style by Professors William Strunk, Jr. and E. B. White, *Words into Type*, *The Chicago Manual of Style*, or GPO's *A Manual of Style)*
- Consistency of references (e.g., in this guidance document the Maternal and Child Health Bureau is called the Maternal and Child Health Bureau or MCHB.)

1. How to Format the Application

MCHB prefers that the format and style of each application substantially reflect the format and style used in this guidance. To promote readability and consistency in organization, MCHB has established specific conventions for the format of the project narrative, its project abstract, and appendices. Conventions for each are discussed below. Wherever conventions for the individual parts of the grant proposal differ, the parts are discussed separately. Otherwise, the specific convention applies to all parts of the grant proposal.

- *Table of Contents*--A Table of Contents is required. Use the Table of Contents of this Guidance as a formatting and style guide.
- *Page Headings*--The name of the project should appear in the top left corner of each page of the project abstract, project narrative, and appendices as a header.
- *Margins*--The initial left and all right margins should be 1 inch. Top, bottom, and right margins should be 1 inch each.
- *Headings and Indentations* --The section headings used in this document are also to be used in your application. Note also the progressive indentation of each subdivision and sub-subdivision. The initial subheadings only are underlined. This visually distinguishes them from their subordinate subdivision. The latter are indented more than their superiors. This is carried out through the text of the document. This format will allow all users to locate desired text efficiently. In addition, it should assist reviewers in quickly locating text under particular subheadings to facilitate comparisons among competing applications.

- *Headings*--Chapter headings in all parts of the grant application should be typed flush left in all caps,

bold type. Subordinate ranks of subheadings are indented in accordance with their respective ranks.

-- *Project Abstract*--Center the words "PROJECT ABSTRACT"
-- *Project Narrative*--Center the words "PROJECT NARRATIVE"
-- *Appendices*--Identify appendices by labeling and titling each appendix. All attachments should be compatible with the suggested format.

- *Page Limit and Spacing*-- Note: If applications exceed the limits specified below, they are subject to being returned without review.
  -- *Project Abstract*--The project abstract may not exceed four pages. Only single-spaced, one-sided pages are acceptable. (See Attachment C.)
  -- *Project Narrative*--The project narrative may not exceed 75 pages. The page limit includes any referenced charts or figures but does not include the project abstract, budget justification, tables, nor appendices. Only single-spaced (with double-spacing between paragraphs), one-sided pages are acceptable. Consecutive, Arabic numerals (beginning with 1) should appear centered at the bottom of each page. Please paginate all charts or figures appearing within the body of the text consecutively with the text.
  -- *Appendices*--Appendices must not exceed 100 pages and must include all supporting documentation, such as (1) suggested consortium roster, (2) organizational chart, position descriptions and curricula vitae, (3) memoranda or letters of agreement and support, and (4) evaluation instruments/plans. Spacing will vary depending on the nature of the appendix, but only one-sided pages are acceptable. Centered at the bottom of each page, label each page of the appendix with the Consecutive Uppercase Letter reflecting the appendix section followed by the page number using Consecutive, Arabic numerals (beginning with 1), e.g., A-1, A-2...B-1, etc.

- *Typeface*--Use any easily readable serif typeface, such as Times New Roman, Courier, or New Century Schoolbook.
- *Type Size*--Size of type must be at least 10-point; 12-point is preferable. Type density must be no more than 15 characters per inch. No more than six lines of type per vertical inch are allowable. Figures, charts, legends, footnotes, etc., may be smaller or more dense, but must be readily legible.
- *Page Numbering*
  -- *Budget*--Consecutive, Arabic numerals (beginning with 1) should appear centered at the bottom of each page
  -- *Table of Contents*--Consecutive, lowercase Roman numerals should appear centered at the bottom of the appropriate page.

2. How to Organize the Application

You should assemble the application in the order shown below:

- Letter Of Transmittal (Applicant data demonstrating that they meet the eligibility factors must be documented in the this letter)
- Table of contents for entire application with page numbers
- SF-424 Application for Federal Assistance
- Checklist included with PHS 5161-1 (Application Kit, pages 25-26)
- SF 424A Budget Information--Non-Construction Programs
- Budget justification (Attachment B)

- Key personnel form (Attachment B-1)
- Federal assurances (SF 424B)
  - Project Abstract (Attachment C)
  - Project Narrative
  - Appendices

3. Copies Required

Applicants are required to submit one ink-signed original and two copies of the completed application. A total of six copies will be used during the review process. Additional submission of three more copies by the applicant is optional. Disk copies of the submitted application narrative and the project abstract in a format which can be imported into Word Perfect for Windows 6.1 must also be submitted.

C. Requirements

To be considered for the Healthy Start Initiative grant under this competition, applicants must meet all of the requirements listed below. If an applicant fails to meet one of these requirements, the application may not be accepted for review and may be returned to the applicant.

- Complete required standard application forms and provide budget justification.
- Document submission of a Public Health System Impact Statement (PHSIS) or Project Abstract to the State Title V MCH Director. (e.g., a letter from Federal or State officials documenting receipt of same)
- Provide a complete application which addresses all review criteria in a substantive manner in the required format.

Each of these requirements is discussed in detail below.

1. Overview of Application Form PHS 5161-1 and Related Program Concerns

An official application is composed of seven sections which are described more fully in the formal grant application form entitled PHS Grant Application Form PHS 5161-1.

- The *first section* contains information about PHS policies and procedures.
- The *second section*, **SF-424**, is the **Face Page** and requests basic information about the applicant and project.
- The *third section*, **SF-424A** (non-construction) pertains to budget information (see pages 11-12 and the budget narrative, page 23).
- The *fourth section*, **SF-424B**, concerns **Assurances** and must be signed by an authorized representative of the applicant organization.
- The *fifth section* concerns **Certifications** (page 13).
- The *sixth section* concerns the program narrative (page 21).
- The *last section* consists of a **Checklist** which must be included with all applications (pages 25-26).

Standard Forms 424C and 424D are not necessary for this application and should be ignored. Selected portions of the instructions are amplified and highlighted here:

- The *Catalog of Federal Domestic Assistance Number* (CFDA) is **93.926E**
- *SF-424, Item 10, for Program Title,* enter the title of this competition: **HSI : Eliminating Disparities in**

Perinatal Health

- **SF-424, Item 13**, enter the dates for the complete project period **June 1, 2000 - May 31, 2004.**

- The following instructions should be used in **completing SF-424A**:

For each part of SF-424A, Section B budget categories, applicants must submit on supplemental sheet(s) an itemized justification for each individual budget category line (6a-j). Applicants typically identify the specific needs, but often fail to write a justification of those needs. These detailed budget justifications require the applicant to show specific references to the project plan related to how the requested dollar amount was developed. Applicants are not required to submit copies of contracts; however, personnel, scopes of work, budgets, and budget justifications of contracts are required by the Grants Management Branch, MCHB. Attachment B provides additional guidance on budget justification.

The Key Personnel Form

Attachment B-1, may be used as a supplement to the budget narrative. Key personnel must be identified by name (if known), total percent of time and salary required under the grant, and if applicable, amounts provided by in-kind or other sources of funds (including other federal funds) to support the position. The budget justification for personnel addresses time commitment and skills required by the project plans. Similar detailed and itemized justifications must be provided for requested travel items, equipment, contractual services, supplies and other categories. Please note that if indirect costs are requested, the applicant must submit a copy of its latest negotiated rate agreement (page 11 of 5161-1). The indirect costs rate refers to the "Other Sponsored Programs/Activities" rate and not the research rate.

2. Public Health System Impact Statement or Project Abstract

The project abstract may be used in lieu of the one-page PHSIS if the applicant is required to submit a PHSIS. See Chapter I, Section C.5.

3. Complete, Responsive Application

Applicants must submit applications, including line item budgets with model specific breakouts, that have been developed in accordance with this application guidance. Each review criterion should be fully addressed and provide the information requested in a substantive manner.

4. Preparing the Appendices

Appendices should be brief and supplemental in nature. Refer to the style and format section of this chapter for specific conventions to be followed in formatting appendices. A list of appropriate appendices follow, along with the order in which they should be submitted

A. Project Area Needs Assessment- all needs assessment data, such as tabular statistical data, maps and charts project and the suggested demographic and statistical data form.
B. Organizational chart for grantee and project; Position descriptions; Documentation of relationships between the proposed program and affiliated departments, institutions, agencies,

or individual providers, and the responsibilities of each, i.e., letters of support, understanding and memoranda of agreement.

C. Evaluation plan for the project. Curriculum vitae of evaluator
D. Current or planned role of consortium members describing the current or planned composition of the primary consortium. As applicable, list the members of the executive/steering committees of the consortium and chairs. Give a description of the structure, role and the composition of the consortium, executive/steering committees. Please specify the members and chairpersons of each of committee.
E. Other

Checklist

Refer to the Checklist for a complete listing of all components to be included in the application:

- *Organizational characteristics* - A chart(s) which identifies the characteristics of the applicant and the relationship with any other grantee agency programs, summarizes lines of authority for all key HSI personnel and reflects the actual or planned lines of communication with the Consortium.

- *Position descriptions* (not to exceed 2 pages each) for all professional and technical positions for which grant support is requested and any positions of significance (this may include contractors) to the program that will be supported by other sources. At a minimum, describe the following:
  - -- Administrative direction and to whom it is provided;
  - -- Functional relationships (e.g. who individual reports to and how does this position fit within its organizational structure;
  - -- Duties and scope of responsibilities;
  - -- Minimum qualifications (e.g. the minimum requirements of education, training, and experience needed to do the job);

- *Curricula Vitae* -- Include vitae, not to exceed 2 pages each, for each planned key management positions. Key project management staff include Project Director/Coordinator, Fiscal Officer, and other relevant staff. Please place these vitae behind the appropriate position description.

CHECKLIST FOR COMPETITIVE APPLICATION
FY 2000

SUBMIT 1 ORIGINAL, INK-SIGNED APPLICATION AND 2 SIGNED COPIES, ALL NUMBERED AND UNBOUND (FOR EASE OF COPYING). INCLUDE THE FOLLOWING:

1. ____ **Letter Of Transmittal including applicant data demonstrating that they meet the eligibility factors**
2. ____ **Table Of Contents For Entire Application With Page Numbers**

Budget Information

3. ____ **SF 424 Application For Federal Assistance**
4. ____ **Checklist Included With PHS 5161-1, (Page 27) *Application Kit*. Provide The Name, Address, And Telephone Number For Both The Individual Responsible For Day-To-Day Program Administration And The Finance Officer.**
5. ____ **SF 424A Budget Information--Non-Construction Programs**
6. ____ **Budget Justification (Includes The Narrative, Supplemental Sheets and Key Personnel Form) (See ATTACHMENT B)**

Federal Assurances

7. ____ **Intergovernmental Review Under E.O. 12372, If Required By State**
8. ____ **SF 424B Assurances--Non-Construction Programs**
9. ____ **Department Certification (45 CFR Part 76)**
10. ____ **Certification Regarding Drug-Free Workplace Requirements**
11. ____ **Certification Regarding Debarment and Suspension**
12. ____ **Lobbying Certification**
13. ____ **Public Health System Impact Statement**

Description Of Program

14. ____ **Project Abstract, Maximum Of Four Pages (see ATTACHMENT A)**
15. ____ **Project Narrative, Maximum Of 75 Pages**
16. ____ **Project Appendices, Maximum Of 100 Pages**

Disk copies of the submitted application narrative and the project abstract in a format which can be imported into Word Perfect must also be submitted.

ATTACHMENT D

PROJECT AREA DEMOGRAPHIC AND STATISTICAL DATA TABLE

Applicant: Sample

VARIABLE	WHITE	BLACK	OTHER	(N) TOTAL	HISPANIC ORIGIN*
1990 Census Data **:					
Population by Racial Distribution (number)**	100,000	50,000	25,000	175,000	15,000
# Women of Child-bearing Age (WCBA)**	31,000	15,500	7,750	54,250	4,650
% Children under 18 in families with incomes below Federal Poverty Level (FPL)**	15%	21%	15%	51%	25%
% Population below 185% FPL **	20%	25%	15%	60%	50%
1995:					
# Live Births	2,385	1,499	889	4,773	496
# Births to Teens 17 years and younger	83	155	30	268	38
# Births to Teens 18 and 19	176	195	45	416	53
# Live Births to women entering care in the first trimester	1,765	1,019	693	3,477	312
# Live Births with No Prenatal Care	790	593	197	1,580	79
# Infant Deaths	31	34	18	83	8
# Neonatal Deaths (28 days or less)	14	23	6	43	3
#Post Neonatal Deaths (29 to 364 days)	17	11	12	40	5
# infants born weighing 2500 grams or less	160	234	94	484	53
# infants born weighing 1500 grams or less	62	61	31	154	30
# infants born with less than 38 weeks gestation	10	11	4	25	2
1996:					
# Live Births	2,001	1,257	751	4,009	480
# Births to Teens 17 years and younger	70	130	25	225	37
# Births to Teens 18 and 19	148	164	38	350	51
# Live Births to women entering care in the first trimester	1,481	855	585	2,921	302
# Live Births with No Prenatal Care	684	532	151	1,367	61
# Infant Deaths	25	28	13	66	7
# Neonatal Deaths (28 days or less)	13	18	6	37	3
#Post Neonatal Deaths (29 to 364 days)	12	10	7	29	4
# infants born weighing 2500 grams or less	134	196	80	410	51

# infants born weighing 1500 grams or less	60	47	32	139	34
# infants born with less than 38 weeks gestation	10	11	4	25	2
VARIABLE	**WHITE**	**BLACK**	**OTHER**	**(N) TOTAL**	**HISPANIC ORIGIN***
1997					
# Live Births	1,779	1,096	657	3,532	467
# Births to Teens 17 years and younger	63	114	22	199	36
# Births to Teens 18 and 19	131	143	33	307	50
# Live Births to women entering care in the first trimester	1,316	745	512	2,573	294
# Live Births with No Prenatal Care	633	475	119	1,227	39
# Infant Deaths	22	24	10	56	6
# Neonatal Deaths (28 days or less)	11	16	5	32	3
#Post Neonatal Deaths (29 to 364 days)	11	8	5	24	3
# infants born weighing 2500 grams or less	119	171	69	359	49
# infants born weighing 1500 grams or less	65	57	55	177	37
# infants born with less than 38 weeks gestation	10	11	4	25	2
Age Appropriate Immunization Rates of Children From Birth to 2 years					
1995				70%	
1997				85%	
# WCBA Receiving Medicaid					
1997	20,000	12,000	8,000	40,000	
(Estimated) % WCBA uninsured					
1997				50%	

ATTACHMENT D-2

PROJECT AREA DEMOGRAPHIC AND STATISTICAL DATA TABLE

Applicant: _____

VARIABLE	WHITE	BLACK	OTHER	(N) TOTAL	HISPANIC ORIGIN*
1990 Census Data:**					
Population by Racial Distribution (number)**					
# Women of Child-bearing Age (WCBA)**					
% Children under 18 in families with incomes below Federal Poverty Level (FPL)**					
% Population below 185% FPL**					
1995:					
# Live Births					
# Births to Teens 17 years and younger					
# Births to Teens 18 and 19					
# Live Births to women entering care in the first trimester					
# Live Births with No Prenatal Care					
# Infant Deaths					
# Neonatal Deaths (28 days or less)					
#Post Neonatal Deaths (29 to 364 days)					
# infants born weighing 2500 grams or less					
# infants born weighing 1500 grams or less					
# infants born with less than 38 weeks gestation					
1996:					
# Live Births					
# Births to Teens 17 years and younger					
# Births to Teens 18 and 19					
# Live Births to women entering care in the first trimester					
# Live Births with No Prenatal Care					
# Infant Deaths					
# Neonatal Deaths (28 days or less)					
#Post Neonatal Deaths (29 to 364 days)					
# infants born weighing 2500 grams or less					
# infants born weighing 1500 grams or less					

# infants born with less than 38 weeks gestation					

VARIABLE	WHITE	BLACK	OTHER	(N) TOTAL	HISPANIC ORIGIN
1997					
# Live Births					
# Births to Teens 17 years and younger					
# Births to Teens 18 and 19					
# Live Births to women entering care in the first trimester					
# Live Births with No Prenatal Care					
# Infant Deaths					
# Neonatal Deaths (28 days or less)					
#Post Neonatal Deaths (29 to 364 days)					
# infants born weighing 2500 grams or less					
# infants born weighing 1500 grams or less					
# infants born with less than 38 weeks gestation					
1998					
# Live Births					
# Births to Teens 17 years and younger					
# Births to Teens 18 and 19					
# Live Births to women entering care in the first trimester					
# Live Births with No Prenatal Care					
# Infant Deaths					
# Neonatal Deaths (28 days or less)					
#Post Neonatal Deaths (29 to 364 days)					
# infants born weighing 2500 grams or less					
# infants born weighing 1500 grams or less					
# infants born with less than 38 weeks gestation					
Age Appropriate Immunization Rates of Children From Birth to 2 years					
1995					
1997					
# WCBA Receiving Medicaid					
1997					

Estimated % of families with WCBA uninsured					
1997					

Attachment E

HEALTHY START MODELS OF INTERVENTION

The mission of the Healthy Start Initiative has been to identify and implement a broad range of community-based strategies for significantly reducing contributing factors to infant mortality and disparities in perinatal health in communities with very high rates. The Healthy Start Initiative supported 22 communities during its demonstration phase which ended in 1997, 15 since 1991, and 7 since 1994. Although the demonstration sites had some program aspects which were unique, many common themes emerged. These themes and the lessons learned in implementing them have formed the foundation for the current Healthy Start Initiative. These themes will be Healthy Start's legacy.

At the start of the Initiative, a great deal was already understood about the chief causes of infant mortality, such as congenital anomalies, complications from low birthweight, and Sudden Infant Death Syndrome. It was also known that early and regular prenatal care is important for healthy pregnancies and birth outcomes. What was not well understood was why more women were not getting the care they needed. Also not understood were the approaches that would break down barriers to care that were already apparent, such as limited availability of health care providers in some urban and rural communities, compounded by lack of accessible transportation to the few providers available.

Each Healthy Start community has examined the factors contributing to infant mortality in its community, the community's needs, and the resources available for designing community-based approaches to reduce infant mortality. From the common themes of the demonstration phase, in addition to the critical need for meaningful involvement of the community consortia, eight service models of intervention emerged along with a host of lessons learned about implementing them successfully and empowering communities to reduce contributing factors to low birthweight and infant mortality, improve positive birth outcomes, and address effectively the well-being and empowerment of mothers, fathers, and families.

As Healthy Start looks to the future, new goals include sustaining successful strategies in Healthy Start communities and replicating these strategies in new communities with high rates of infant mortality and other disparities in perinatal and women's health, using the current sites as mentors. These models of intervention will guide the new communities and others as they seek to replicate or adapt programs and strategies to address their unique circumstances.

Healthy Start's models all focus on the same goal: community-based reduction of contributing factors to infant mortality and adverse perinatal outcomes. The models accomplish this through community-based services integration, especially for those clients at highest risk.

The following information delineates each Healthy Start Intervention Model, including the definition, purpose, anticipated results, essential components, suggested needs assessment indicators, and suggested performance indicators. The information is not meant to be restrictive or all-encompassing, but to encourage communities in the formulation of individualized adaptations of the models.

1. Healthy Start Organizational Model: Community-based Consortium

At the heart of the Healthy Start Initiative is the belief that the community, guided by a consortium of individuals and organizations--including families, community leaders, and organizations from the private, public, and nonprofit sectors--can best design and implement the services needed by the families in that community. Advised by the consortia, each Healthy Start project focuses the power of collaboration on the problem of infant mortality. ***The community-based consortium is a required model***.

Definition

Use of a local community-based consortium/advisory board of consumers (i.e., recipients of project services residing in the catchment area), providers, public and private health and social services agencies, community action agencies, religious organizations, schools, businesses, and others in an advisory capacity for program planning, operations, monitoring, and evaluation.

Purpose

To partner with the community to reduce infant mortality and adverse perinatal outcomes by providing a formal means of two way communication between the project and the community throughout the life of the project.

Anticipated Results

- Community capacity and infrastructure are strengthened;
- Programs that reflect community needs and values are developed and strengthened;
- Community knowledge of and investment in the IMR effort are increased;
- Community and institutional coordination and collaboration are increased;
- Community understanding of all facets of infant mortality reduction strategies is increased.

Essential Components

- *Time to build consortia*. Consortium development is a complex, labor intensive process that requires long-term team-building activities involving consumers, providers, and public/private sector entities.
- *Membership should reflect the cultural diversity of the community,* and should include small, community-based organizations whose capacity will be enhanced by participation in the consortium.
- *Sub-structures allowing for increased opportunities* for direct participation and pertinent focused functions, including sub-consortia representing neighborhoods.
- *Balance of stakeholders* between community, consumer, and provider membership.
- *Mechanisms for conflict resolution* and the ability to avoid conflicts of interest.
- *Support for community participation*, including training, child care, transportation, and observance of local cultural customs.
- *Participation* in all phases of the project, including decision-making.
- *Sustainable infrastructures* built on community ownership and empowerment.

Suggested Assessment Indicators

- Ethnic/racial diversity of consortium is congruent with that of the project area;

- Percentage of consumers in total consortium membership at beginning of project;
- Number of other collaboratives represented on consortium at beginning of project;
- Ratio of public to private agencies/providers actively involved in the community at the beginning of the project.

Suggested Performance Indicators to be Used in Formulating Objectives:

- The degree of consumer participation in the work of the consortium on program and policy directions for the Healthy Start Initiative; and
- Increase the capacity (knowledge and skills) of consortium members through provided training.

Additional Performance Indicators Which Could Be Used In Formulating Objectives:

- Plan for continuing program services without federal funding.
- Evidence of services integration, including number of joint training across agencies, shared data, and common data systems

2. <u>Healthy Start Service Intervention Model: Care Coordination/Case Management</u>

For HSI Phase II, beginning with all communities initially funded in BY 99/2000 this is a required model.

Definition

The coordination of services across providers to meet a client's identified needs through client assessment, monitoring, facilitation, and follow-up on utilization of needed services.

Purpose

To coordinate services from multiple providers to assure that each family's individual needs are met to the extent resources are available, and the client agrees with the scope of planned services.

Anticipated Results

- Access to services is increased;
- Consumer empowerment and satisfaction is increased;
- Follow-through with service plans is increased;
- Community and institutional coordination and collaboration is developed and increased.

The coordination of the total care of pregnant and parenting women and their families is a cornerstone of Healthy Start. Relying on direct relationships between case managers and families, care coordination helps ensure that families can access the medical, health, and social services they need, and that projects know what system barriers families face. Care coordination is family-level services integration: care management's goal is to make services and systems work together to meet each family's needs. Case managers realize that individualized needs assessments and service plans developed in concert with the woman and her family are more likely to be followed than plans that are made for women. This process empowers and educates, rather than directs women.

Essential Components:

- *Broad scope of services*, including education, prevention, and intervention. Coordination helps

ensure that families are knowledgeable about the services available, receive the services they need, that referrals are made and completed, and that gaps in services are minimized or avoided.

- *Pro-active partnerships* between case managers, families, service providers, and the community. Case managers must know the resources as well as they know the clients. Only when case managers have active partnerships with all involved in service delivery can appropriate services for each family be coordinated.
- Individualized needs assessments and service plans developed with families. This process puts each individual at the center of care coordination.
- *Service intensity that matches level of risk*. When all clients' risk levels are identified, program resources are more effectively divided among consumers of services. For example, first-time parents and families with histories of violence or substance abuse receive more intense services than families without such histories.
- *Service delivery at sites in the community*, including homes. This maximizes contact with clients by bringing the case managers to the clients. Working in the community gives case managers more first hand knowledge of each family's environment, behaviors, and needs.
- *Case managers who advocate* for systems change on behalf of their clients. Advocacy is the method for bringing the case managers' knowledge of the community back to the health care system, including their own programs. In this way, care coordination is crucial to reducing barriers to care.
- *Ongoing training of community-based case managers*. Training ensures that case managers have the most up-to-date information, continued skill development, and ongoing support necessary to coordinate care. Because case managers often come from the communities in which they work, training is a source of economic development for the community.

Suggested Needs Assessment Indicators:

- Number of women who enter prenatal care, by trimester, and the number of women who receive no prenatal care;
- Projected number of perinatal clients to be recruited;
- Number of abuse/neglect cases among infants in project area;
- Number, and scope/purpose of other case management programs serving same targeted population in same project area;
- Prevalence of any risk factor among pregnant women and infants in the project area.
- Average annual number of visits by perinatal women and/or infants in Emergency Rooms in hospitals serving the project area (other than for delivery or *ambulatory-sensitive care);
- Number of "no-shows" for newborn two-week assessment or first well baby visit;
- Average length of hospital stay for high risk newborns after mother is discharged.

Suggested Performance Indicators To Be Used In Formulating Objectives:

- Increased percentage of completed referrals among infants (i.e., client seen by provider s/he was referred to be seen);
- Increased percentage of completed referrals among prenatal clients (i.e., client seen by provider s/he was referred to be seen);
- Increased percentage of completed referrals among infant clients with special health care needs (i.e., client seen by provider s/he was referred to be seen); and
- Percent of participating postpartum women who receive interconceptional services.

3. Healthy Start Service Intervention Model: Outreach & Client Recruitment

Definition:

Provision of case finding services which actively reach out into the community to recruit perinatal clients.

Purpose:

To identify and enroll clients most in need of Healthy Start services.

Anticipated Results:

- Community knowledge of IMR efforts is increased;
- Access to services is increased;
- Identification of community needs, and those most in need of services is increased;
- Enrollment in perinatal care, including Healthy Start services, care coordination, and health and social services is increased;
- Job training and employment opportunities for community members are increased.

To fulfill their mission, Healthy Start projects must provide services to those who are most difficult to reach. Client recruitment, through proactive outreach, provides a door to families who have been underserved by the health and social service systems. Relying on community members themselves, Healthy Start projects are able to recruit more clients earlier in their pregnancies. Trained community residents go door-to-door and to other community locations to find women and promote the importance and availability of Healthy Start services. Frequently outreach workers then work with individual families whom they have contacted to help them access needed services and complete application and eligibility processes. Such resourceful efforts help to remind and encourage these women to obtain the care they need.

Essential Components:

- *Creative and diverse outreach strategies*, including targeting a variety of locations.
- *Indigenous outreach workers* who live in the community, are familiar with the area, and "speak the language" are most effective in reaching the women in the greatest need of care. Many outreach programs provide an avenue of employment that enhances self-esteem and provides individual with a greater sense of personal responsibility and contribution toward the improvement of the neighborhood and community.
- *Outreach workers who are full members of the health care team*. Outreach workers are the conduit for messages to and from members of the community and need to be recognized and used as an integral part of the provider team.
- *Ongoing outreach worker training* that not only serves the needs of clients, but provides professional and economic development opportunities for the community and its members. Some outreach training programs provide college credits to help workers advance their education and professional development. Training also provides the support necessary to coordinate care.
- *Close coordination with case managers* to assure that those identified as needing services actually receive those services.

Suggested Needs Assessment Indicators*:*

- Number of clients per outreach worker;
- Number of women who enter prenatal care, by trimester, also including the number of women who receive no prenatal care;
- Projected number of perinatal clients to be recruited;
- Current number of outreach workers serving project area;
- Number and scope/purpose of other outreach programs serving same project area, including number of workers involved.

Suggested Performance Indicators To Be Used In Formulating Objectives:

- Number of infants one year of age or younger who have been recruited and receiving services; and,
- Number of pregnant women who have been recruited and receiving services.

4. <u>Healthy Start Service Intervention Model: Enhanced Clinical Services</u>

Definition:

Improvement of quality, availability and access, and utilization of clinical services that are usually offered by providers such as health department clinics, hospitals, and community clinics.

Purpose:

To improve accessibility, quality, and client satisfaction of existing perinatal health services.

Anticipated Results:

- Access to services is increased;
- Consumer satisfaction with services is increased;
- Institutional capacity and quality is developed and strengthened.

In many Healthy Start communities, existing services were not adequate to meet the community's needs. The Healthy Start communities developed strategies to enhance the quality, access, utilization, and client satisfaction levels of clinical services usually provided by agencies such as health department clinics, hospitals, and community clinics. Depending on community needs, these strategies might include increasing numbers of available providers/specialists, expanding hours or location of services, creating clinic atmospheres and protocols that are more welcoming to fathers and male partners, and conducting cultural sensitivity training for providers. Enhancing cultural understanding improves the climate of care and, in turn, pregnant and parenting women are more likely to follow through on provider recommendations.

Essential Components:

- *Holistic approach to client families* usually increases providers' satisfaction and makes their workloads more manageable, helping retain current providers and attract new providers.
- *Relating services to the needs, priorities and values of the community* increases use of services.
- *Attention to details*. Even small changes that may be perceived as unworthy of expenditures- such as obstetrical office decor that appeals to both mothers and fathers-can make clients feel more welcome and respected.
- *Collaboration with clinical service providers*. Change cannot be made without support and buy-in from community providers.
- *Community knowledge of enhanced services*.

- *Continuous feedback from consumers and providers.*

Suggested Needs Assessment Indicators:

- Number of women who enter prenatal care, by trimester, also including the number of women who receive no prenatal care;
- Average waiting period for first prenatal appointment for clients in project area (number of days between call and appointment); average number of visits by prenatal clients/pregnancy;
- Average number of prenatal clients who are at high risk of poor pregnancy outcome;
- Number of active FTE providers by service type (e.g., pediatricians, neonatologists, perinatalogists, OBs/CNMs) serving project area population;
- Number/frequency of continuing education/orientation sessions for all service providers on cultural sensitivity;

Suggested Performance Indicators To Be Used In Formulating Objectives*:*

- Measure of client satisfaction with enhanced clinical services.

5. Healthy Start Service Intervention Model: Family Resource Centers

Definition:

Provision of a community-driven, comprehensive array of client services at a single, accessible community location.

Purpose:

To provide access to related services in one central location;

Anticipated Results:

- Community capacity and infrastructure is developed and increased;
- A hub for community health activities is created;
- Access to services is increased;
- Services that reflect community needs and values are developed;
- Community and institutional coordination and collaboration is increased.

Healthy Start communities have demonstrated the positive impact of providing multiple services under one roof in an accessible community location. Commonly called "one-stop shopping", the concept encompasses co-locating existing maternal and pediatric primary health care with on-site Special Supplemental Nutrition for Women, Infants and Children (WIC) and/or Medicaid eligibility processing, health education programs, counseling and support services, employment, and other programs. Family resource centers minimize the number of places clients must go for services, and reduce the number of forms they must complete. This increases the chance that clients will have access to and make use of the care and services they need.

Essential Components:

- *Providing an array of family-centered services* creates a hub of community health activities that promotes health and serves the needs of the community.
- *Community involvement* in planning and guidance of the centers assures that services provided are

tied to the needs, priorities, and resources of the community.
- *Collaboration with existing community resources* creates opportunities to bring services together, whether by co-location or by increased coordination, and to maximize knowledge of their existence and therefore increase utilization.

Suggested Needs Assessment Indicators:
- Average waiting period for first prenatal appointment for clients in project area (number of days between call and appointment);
- Average number of visits by prenatal clients during pregnancy;
- Number of clients currently using each service proposed to be co-located;
- Average monthly number of 'no-shows' for each service proposed to be co-located in relation to the total number of appointments;

Suggested Performance Indicators To Be Used In Formulating Objectives:
- Measure of client satisfaction with quality, culturally competent co-located services; and
- The proportion of kept appointments to scheduled appointments at the Family Resource Center for a reporting period.

6. <u>Healthy Start Service Intervention Model: Risk Prevention and Reduction</u>

Definition:

Provision of specialized services which address population-based or system-oriented issues to reduce, modify, or eliminate specific stressors or unhealthy behaviors that threaten childbearing women and their families.

Purpose:

To reduce risks particularly associated with infant mortality in specific communities.

Anticipated Results:
- The incidence of stressors or unhealthy behaviors which are known to impact infant mortality is decreased;
- Access to services is increased;
- Intensity of intervention for those most at risk for infant mortality is increased;
- Community and institutional coordination and collaboration is increased;
- Job training and employment opportunities for community members are increased.

Healthy Start communities have focused specialized services on families experiencing stressors or practicing behaviors that threaten their health and well-being. This model of intervention provides services that prevent, reduce, or eliminate such stressors as family violence, child abuse, depression, smoking, substance abuse, neighborhood crime, economic decline, homelessness, and families struggling to keep father figures involved. Involving male partners in all areas of services has positive long-term effects on the birth outcome, the mother and her partner. Educational programs such as parenting and smoking cessation classes provide support to pregnant women and their families attempting to change behaviors and reduce risk. Infant Mortality Reviews assist with identification of systems issues and provide opportunities for

community education and input.

Essential Components:

- *Expansion of existing services*, targeted toward specific stressors/behaviors known to negatively impact on pregnancy outcomes, to include both pregnant women and their families (e.g., substance abuse treatment, child abuse prevention).
- *Risk assessment and identification protocols* that identify areas of greatest concern for each client.
- *Staff with specialization in risk areas* must be recruited and retained.

Suggested Needs Assessment Indicators:

- Incidence of targeted risk factor (e.g. smoking, substance abuse, family violence) currently among families of pregnant women in project area;
- Number, scope and current utilization and/or length of average waiting periods of other programs providing similar risk reduction activities to targeted population residing in project area;
- Prison health: number of female inmates who are pregnant; current scope of prenatal services, substance abuse treatment and counseling, and transitional care available to inmates; level of support services available for all family members during perinatal period. Number, scope and current utilization of other programs providing similar risk reduction activities to inmates in same institution/halfway house.

Suggested Performance Indicators To Be Used In Formulating Objectives:

- Incidence of risk behaviors such as smoking, substance abuse, family violence and inadequate diet among pregnant and parenting women and adolescents after receiving specific Healthy Start funding Risk Reduction intervention; and
- Improvement in the quality and impact of Fetal and Infant Mortality Reviews (FIMR) by demonstrating enhancement in the following areas:
  1. Representation of the six groups on the project FIMR's Case Review Team (CRT):
  2. Expected FIMR Reviews compared to total number of infant mortality cases in the Project Area during the reporting period.
  3. Case Record Abstractions completed compared to the number of cases expected to be reviewed during the reporting period.
  4. Maternal FIMR interviews completed compared to the number of cases expected to be reviewed during the reporting period.
  5. CRT Case reviews completed compared to the number of cases expected to be reviewed during the reporting period.
  6. Number of actions instituted by project administration as a result of FIMR recommendations compared to number of FIMR recommendations sent to project administration.
  7. Number of actions instituted by project's Consortium as a result of FIMR recommendations compared to number of FIMR recommendations sent to project's Consortium.

Healthy Start Service Intervention Model: Facilitating Services

Definition:

Provision of enabling services such as translation, transportation, and child care to assist clients in receiving services and participation in infant mortality programs.

rpose:
To reduce logistical barriers to accessing services and activities.

ticipated Results:
- Access to services is increased;
- The number of missed appointments is decreased;
- Provider and consumer satisfaction is increased;
- Community participation in Healthy Start services and activities is increased.

In many Healthy Start communities, services were difficult to access even when they were available. Consumers lacked the resources to reach the services, and/or the location of the services was inaccessible to them. By facilitating access to existing and new services, Healthy Start sites are able to capitalize on many community resources and achieve greater utilization of services.

sential Components:
- *Coordinated transportation to service sites, or mobile services* to increase the number of women reaching service locations.
- *Trained transportation providers who treat clients with respect*. It is helpful when transportation providers are trained to give health education and to serve as part of the health care case management team.
- *On-site or drop-in child* care to allow women to bring children with them to appointments, and to leave them in care while attending to their own needs or needs of their other children. Child care can be staffed in part by college students as a practicum for child development courses.• *On-site access to bilingual staff*, orally proficient in foreign languages prevalent in the target community.
- *Collaboration with existing community resources* that provide facilitating services..

ggested Needs Assessment Indicators*:*
- Number of clients who attribute failure to keep appointments to their lack of transportation and/or child care, in relation to the total number of clients;
- Number of clients who attribute failure to keep appointments to the lack of translation services in relation to the total number of clients whose primary language is not English;
- Number and scope of existing sources of facilitating services;
- Client and provider knowledge of existing facilitating services;
- Utilization rates for existing facilitating services.

ggested Performance Indicators To Be Used In Formulating Objectives*:*
- Measure of client satisfaction with specified facilitating services.

Healthy Start Service Intervention Model: Education and Training

finition:
Provision of planned education and public information to address risk factors associated with infant mortality, and to improve individual and community health.

rpose

To educate the public, clients, and providers regarding health issues and other topics that promote perinatal health and/or enhance the delivery of perinatal care.

ıticipated Results:

- Community knowledge of and involvement in IMR efforts are increased;
- Health knowledge and behaviors among clients and community members are improved;
- Job training and employment opportunities for community members are increased;
- Knowledge and skills in the health care work force are improved.

Essential groundwork for a Healthy Start project includes increasing a community's awareness of infant mortality, its contributing factors, and the strategies for combating it. Creative events, media outreach, and other strategies have been employed by every Healthy Start site. Once aware of the issues, Healthy Start clients and community members can access specific health education programs aimed at reducing infant mortality, including nutrition education, childbirth training, parenting education, and others.

In addition, Healthy Start sites have provided training and curricula for those who deliver health services. Healthy Start projects have developed curricula on a variety of perinatal service components including outreach worker training manuals; childbirth education and parenting education curricula; consortium training and consumer empowerment; and other audiovisual training and marketing aids. The linkage of these trainings with college credit/CEUs provides an incentive for greater participation.

***sential Components*:**

- *Public information and education campaigns* that elevate community awareness of infant mortality issues, including creative communication strategies such as bus signs, radio talk shows on local stations, and grocery bag advertisements.

- *Collaboration with existing community resources*. Community service directories address the ongoing need to identify available providers and services.
- *Opportunities for education and training* that enhance the economic development of the community.
- *Curricula that can be adapted to fit the specific needs and culture of a community.*

***ggested Needs Assessment Indicators**:*

- Number, scope and current utilization of other programs providing similar educational activities to targeted population;
- Length of average waiting periods of other programs providing similar educational activities to targeted population;
- Anticipated level of demand for training by recipients of training (e.g. outreach workers);
- Anticipated level of community need for the newly skilled recipients of training;
- Baseline knowledge level of anticipated recipients of training.

***ggested Performance Indicators To Be Used In Formulating Objectives**:*

- The number of professionals or paraprofessionals trained in this model's activities; and
- Change in prevalence of risk behaviors such as smoking, substance abuse, family violence and behaviors that lead to poor perinatal outcomes after completion of training.

Healthy Start Service Intervention Model: Adolescent Programs

finition:

Provision of services which focus on the unique needs of adolescents to help them understand the complexities of childbearing and the need for pregnancy prevention.

rpose:

To decrease adolescent pregnancy and to improve health care and parenting skills for pregnant and parenting adolescents.

***ticipated Results**:*

- Adolescents' life skills are developed;
- Birth rates among adolescents are decreased;
- Birth outcomes for pregnant adolescents are improved;
- Intensity of intervention for those most at risk for infant mortality is increased;
- Community and institutional understanding, coordination, and collaboration around adolescent health issues are increased;
- Adolescent utilization of and access to services are increased.

Since a significant percentage of low birthweight babies are born to adolescents, they are crucial allies in the fight against infant mortality. Although at-risk, pregnant, or parenting teens require all of the same services as older women, these services must be designed to meet adolescents' special needs, to engage them, and to capitalize on the unique prevention opportunities they present. Healthy Start sites provide information and activities that encourage healthy behaviors, improve self-esteem, and promote abstinence; and that help adolescents, male and female, understand the risks of pregnancy as well as the challenges of parenting.

Young people need support and services to encourage abstinence and to feel involved in social interactions while being empowered to postpone having babies.

sential Components:

- *Adolescent involvement* in planning, implementation, and evaluation of services that makes services more attractive while giving teens hands-on experience in planning and implementing programs.
- *Peer education and counseling* programs through various activities, including artistic expression.
- *Involvement of both adolescent males and females.*
- *Collaboration with schools* to implement school-based health and pregnancy prevention programs that promote healthy lifestyles.

ggested Needs Assessment Indicators:

- Pertinent statistics: school drop-out rate; rate of births to teens for two groups-fourteen and under and fifteen through seventeen; incidence of STDs among teen population; teen suicide rate; runaway and/or homeless rate; incidence of child physical and sexual abuse; major crimes committed by adolescents; employment/jobless rates;
- Number, scope and current utilization and/or length of average waiting periods of other programs providing similar activities to teens residing in project area;
- Education: enrollment and capacity trends of high schools serving the project area; graduation rates; pregnant teens staying in school; availability of day care or alternative education programs; average SAT and similar scores by school; scope and availability of after-school activities/sports; availability of health education and abstinence programs.

ggested Performance Indicators To Be Used In Formulating Objectives*:*

- Percentage of adolescent clients who report that they have better life skills after receiving specific Healthy Start adolescent model intervention; and
- Change in attitudes, skills, and/or knowledge level of risk behaviors such as smoking, substance abuse, family violence, lack or
  early and continuous health care among adolescents after completion of intervention.

Attachment F

EALTHY START PHASE II

ROJECT AREA CONSORTIUM ROSTER

oject: _____

NAME	AGENCY/ORGAN. REPRESENTED	Consumer	Provider	State/Local Government	Regional/Service Area Consortium	Other

ATTACHMENT G

DATA REPORTING REQUIREMENTS

riables Describing Healthy Start Participants

- Pregnant participants described by race, ethnicity, age, Medicaid status, entry into prenatal care, and adequacy of prenatal care;
- Number of deliveries;
- Postpartum participants described by race, ethnicity, age, Medicaid status, and postpartum medical care;
- Infant participants described by race, ethnicity, and well child visits;
- Number of infant deaths; and
- Characteristics of Healthy Start families including smoking, housing, domestic violence, and family support.

riables describing services provided by Healthy Start projects

- Medical services including prenatal clinic visits, well baby/pediatric clinic visits, immunizations, and family planning;
- Adolescent services including adolescent pregnancy prevention, services specific to pregnant teens, services specific to parenting teens, adolescent health services, and youth empowerment/mentoring programs;
- Case management and outreach services including families assisted through case management, outreach, and home visiting;
- Facilitating services including assistance with transportation, translation, and child care;
- Psychosocial services including substance abuse treatment and counseling, HIV/AIDS treatment and counseling, health education services addressing nutrition, HIV/AIDS education, parenting education, childbirth education, and smoking cessation, male support services, housing assistance referrals, job training, mental health services, and prison/jail initiatives; and
- Education and training including consortia training, provider training and public information/education.

mmon Performance Indicators

- Percent of 1-year-olds who have received the full schedule of age-appropriate immunizations against measles, mumps, rubella, polio, diphtheria, pertussis, tetanus, H. Influenza, and hepatitis B;
- Percent of pregnant Healthy Start participants who initiate prenatal care in the first trimester of pregnancy;
- Percent of Low Birth Weight infants born to women who prenatally received Healthy Start services;
- Percent of Very Low Birth Weight infants born to women who prenatally received Healthy Start services;
- Percent of Preterm infants born to women who prenatally received Healthy Start services;
- Percent of Small for Gestational Age infants born to women who prenatally received Healthy Start services;
- The degree of consumer participation in the work of the consortium on program and policy directions for the Healthy Start Initiative; and
- Increased percentage of clients who speak English as a Second Language who enter prenatal care in first trimester.

del Specific Performance Indicators (Consortium)

- Increase in the capacity (knowledge and skills) of consortium members through provided training.

del Specific Performance Indicators (Case Management)

- Increased percentage of completed referrals among infants (i.e., client seen by provider s/he was

referred to be seen);
- Increased percentage of completed referrals among prenatal clients (i.e., client seen by provider s/he was referred to be seen);
- Increased percentage of completed referrals among infant clients with special health care needs (i.e., client seen by provider s/he was referred to be seen); and
- Percent of participating postpartum women who receive interconceptional services.

odel Specific Performance Indicators (Outreach)
- Number of infants one year of age or younger who have been recruited and receiving services; and
- Number of pregnant women who have been recruited and receiving services.

odel Specific Performance Indicators (Family Resource Centers)
- Measure of client satisfaction with quality, culturally competent co-located services; and
- The proportion of kept appointments to scheduled appointments at the Family Resource Center for a reporting period.

odel Specific Performance Indicators (Enhanced Clinical Services)
- Measure of client satisfaction with enhanced clinical services.

odel Specific Performance Indicators (Facilitating Services)
- Measure of client satisfaction with specified facilitating services.

odel Specific Performance Indicators (Risk Prevention and Education)
- Incidence of risk behaviors such as smoking, substance abuse, family violence and inadequate diet among pregnant and parenting women and adolescents after receiving specific Healthy Start funding Risk Reduction intervention; and
- To increase the number quality and impact of Fetal and Infant Mortality Reviews (FIMR) by demonstrating improvement in the following areas:
- Representation of the six groups on the project FIMR's Case Review Team (CRT):
- Expected FIMR Reviews compared to total number of infant mortality cases in the Project Area during the reporting period.
- Case Record Abstractions completed compared to the number of cases expected to be reviewed during the reporting period.
- Maternal FIMR interviews completed compared to the number of cases expected to be reviewed during the reporting period.
- CRT Case reviews completed compared to the number of cases expected to be reviewed during the reporting period.
- Number of actions instituted by project administration as a result of FIMR recommendations compared to number of FIMR recommendations sent to project administration.
- Number of actions instituted by project's Consortium as a result of FIMR recommendations compared to number of FIMR recommendations sent to project's Consortium.

SAMPLE CALENDAR YEAR OBJECTIVES/IMPLEMENTATION PLAN MODEL: Case Management **ATTACHMENT H**

Objective	Evaluation Process & Timeframe	Strategy	Activity, Key Personnel & Timeframe	Collaboration	Progress
CMT3 By 12/31/00, 80% of the postpartum women who were enrolled in the case management program will make at least one visit to a health care provider for interconceptional/fam plan services. (Baseline: 280 of 400 or 70%, of postpartum women enrolled in case management, reported making a postpartum or interconceptional visit to a health care provider. (Source: case management log, patient, provider and program records) city vital statistics)	Analysis of case management logs, questionnaire to postpartum participants to occur 1/30/00 by project evaluator. HD and/or consultants to administer pre and post tests for each in-service training. Analysis of sample set of participant records to determine barriers to receiving prenatal care to occur each quarter by the Case Management Team.	Develop a prenatal teaching program to stress the importance of family planning. Aggressive follow up of postpartum women.	Patient educator to work with case management team to develop patient teaching program. (June- July 2000) Home visiting team to implement new curriculum that includes interconceptional/family planning services as part of prenatal teaching. (July - December 2000) Case management team to develop a hospital visit post delivery protocol to reinforce need for postpartum services .(June -December 2000) Case management team to develop a protocol for telephone follow up and referral at one week prior (to patient); and one week after (to health care provider) postpartum visit. (June - December 2000) Case management team to refer those woman who miss appointments to outreach workers for follow up. (June - December 2000)	Work with local health providers to establish referral system. Work with local hospital to establish in hospital teaching program. Partner with all health care providers to establish data collection method.	For this guidance, this column is not applicable.

ATTACHMENT I

FORMAT FOR LOCAL EVALUATION PLAN

PROJECT: _____ City, State_____
Reporting Period: _____
Local Evaluator: _____Date of Report: _____

I. Introduction

Introduction should include:
- an overview of your project's local evaluation plan;
- a description of how project objectives will be evaluated;
- health outcome performance indicators to be used in evaluation;
- a description of how performance indicators will be tracked;
- instrument development and data collection methods for planned evaluations tracking performance measures (Place in Appendix).

II. Activities

Describe:
- timeframed evaluation activities planned for years 0-4 indicating whether the activities will be reported collectively or by service models;
- problems to overcome with appropriate solutions;